	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
****	FI Inpatient SNF Claim Record	REC	VAR			Fiscal intermediary inpatient/SNF claim record for version I of the NCH.
						STANDARD ALIAS: FI_IP_SNF_CLM_REC SYSTEM ALIAS: UTLIPSNI
****	DESY Header Group	GROUP	50	1	50	DESY header for whole record output.
1.	DESY System User	CHAR	30	1	30	A user-defined field that holds the description of the request. For example, "Cross-referenced HICS".
						STANDARD ALIAS: DSY_SYSTEM_USER
2.	Filler	CHAR	11	31	41	Filler
						STANDARD ALIAS: DSY_TBD
3.	DESY Sort Key	CHAR	9	42	50	This field contains the key to tie claims together for one beneficiary regardless of HICAN.
						STANDARD ALIAS: DSY_SORT_KEY
****	FI Inpatient SNF Claim Fixed Group	GROUP	805	51	855	Fixed portion of the fiscal intermediary inpatient/SNF claim record for version I of the NCH nearline file.
						STANDARD ALIAS: FI_IP_SNF_CLM_FIX_GRP
****	Claim Record Identification Group	GROUP	8	51	58	Effective with Version 'I' the record length, version code, record identification, code and NCH derived claim type code were moved to this group for internal NCH processing.
						STANDARD ALIAS: CLM_REC_IDENT_GRP
4.	Record Length Count	PACK	3	51	53	Effective with Version H, the count (in bytes) of the length of the claim record.

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NOTE: During the Version H conversion this field
       was populated with data throughout history
       (back to service year 1991).

5 DIGITS SIGNED

DB2 ALIAS: REC_LNGTH_CNT
SAS ALIAS: REC_LEN
STANDARD ALIAS: REC_LNGTH_CNT

SOURCE:
NCH

5. NCH Near-Line Record   CHAR   1   54   54   The code indicating the record version of the Nearline file
   Version Code   where the institutional, carrier or DMERC claims data are
                                                            stored.

			POSITIONS		
NAME	TYPE	LENGTH	BEG	END	CONTENTS
----------------------------	----	------	---------		---

DB2 ALIAS: NCH_REC_VRSN_CD
SAS ALIAS: REC_LVL
STANDARD ALIAS: NCH_NEAR_LINE_REC_VRSN_CD
TITLE ALIAS: NCH_VERSION

CODES:
A = Record format as of January 1991
B = Record format as of April 1991
C = Record format as of May 1991
D = Record format as of January 1992
E = Record format as of March 1992
F = Record format as of May 1992
G = Record format as of October 1993
H = Record format as of September 1998
I = Record format as of July 2000

COMMENT:
Prior to Version H this field was named:
CLM_NEAR_LINE_REC_VRSN_CD.

SOURCE:

```
6. NCH Near Line Record         CHAR    1   55   55  A code defining the type of claim record being processed.
   Identification Code
                                                     COMMON ALIAS: RIC
                                                     DB2 ALIAS: NEAR_LINE_RIC_CD
                                                     SAS ALIAS: RIC_CD
                                                     STANDARD ALIAS: NCH_NEAR_LINE_RIC_CD
                                                     TITLE ALIAS: RIC

                                                     CODES:
                                                       REFER TO: NCH_NEAR_LINE_RIC_TB
                                                                 IN THE CODES APPENDIX

                                                     COMMENT:
                                                     Prior to Version H this field was named:
                                                     RIC_CD.

                                                     SOURCE:
                                                     NCH


7. NCH MQA RIC Code             CHAR    1   56   56  Effective with Version H, the code used (for internal
                                                     editing purposes) to identify the record being processed
                                                     through HCFA's CWFMQA system.

                                                     NOTE:  Beginning with NCH weekly process date 10/3/97 this
                                                            field was populated with data. Claims processed prior
                                                            to 10/3/97 will contain spaces in this field.

                                                     DB2 ALIAS: NCH_MQA_RIC_CD
                                                     SAS ALIAS: MQA_RIC
                                                     STANDARD ALIAS: NCH_MQA_RIC_CD
                                                     TITLE ALIAS: MQA_RIC
```

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                            POSITIONS
            NAME                 TYPE  LENGTH BEG  END                            CONTENTS
   ---------------------------   ----  ------ ---------  ------------------------------------------------------------
```

```
                                                     CODES:
                                                     1 = Inpatient
                                                     2 = SNF
                                                     3 = Hospice
                                                     4 = Outpatient
```

```
                                inpatientsnf.txt
                        5 = Home Health Agency
                        6 = Physician/Supplier
                        7 = Durable Medical Equipment

                        SOURCE:
                        NCH QA PROCESS

8. NCH Claim Type Code        CHAR    2    57    58   The code used to identify the type of claim record being
                                                     processed in NCH.

                        NOTE1:   During the Version H conversion this field was
                                 populated with data through- out history (back to
                                 service year 1991).

                        NOTE2:   During the Version I conversion this field was
                                 expanded to include inpatient 'full' encounter
                                 claims (for service dates after 6/30/97).
                                 Placeholders for Physician and Outpatient encounters
                                 (available in NMUD) have also been added.

                        DB2 ALIAS: NCH_CLM_TYPE_CD
                        SAS ALIAS: CLM_TYPE
                        STANDARD ALIAS: NCH_CLM_TYPE_CD
                        SYSTEM ALIAS: LTTYPE
                        TITLE ALIAS: CLAIM_TYPE

                        DERIVATION:
                        FFS CLAIM TYPE CODES DERIVED FROM:
                          NCH CLM_NEAR_LINE_RIC_CD
                          NCH PMT_EDIT_RIC_CD
                          NCH CLM_TRANS_CD
                          NCH PRVDR_NUM

                        INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                          (Pre-HDC processing -- AVAILABLE IN NCH)
                          CLM_MCO_PD_SW
                          CLM_RLT_COND_CD
                          MCO_CNTRCT_NUM
                          MCO_OPTN_CD
                          MCO_PRD_EFCTV_DT
                          MCO_PRD_TRMNTN_DT

                        INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                          (HDC processing -- AVAILABLE IN NMUD)
                                      Page 4
```

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                    POSITIONS
          NAME              TYPE  LENGTH BEG   END                              CONTENTS
----------------------------  ----  ------ ---------   ------------------------------------------------------------
                                                        INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED
                                                        FROM: (HDC processing -- AVAILABLE IN NMUD)
                                                          FI_NUM
                                                          CLM_FAC_TYPE_CD
                                                          CLM_SRVC_CLSFCTN_TYPE_CD
                                                          CLM_FREQ_CD
                                                        NOTE:  From 7/1/97 to the start of HDC processing(?),
                                                        abbreviated inpatient encounter claims are not
                                                        available in NCH or NMUD.

                                                        PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                          (AVAILABLE IN NMUD)
                                                          CARR_NUM
                                                          CLM_DEMO_ID_NUM

                                                        OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                                                          (AVAILABLE IN NMUD)
                                                          FI_NUM

                                                        OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
                                                        DERIVED FROM:  (AVAILABLE IN NMUD)
                                                          FI_NUM
                                                          CLM_FAC_TYPE_CD
                                                          CLM_SRVC_CLSFCTN_TYPE_CD
                                                          CLM_FREQ_CD

                                                        DERIVATION RULES:

                                                          SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
                                                          FOLLOWING CONDITIONS ARE MET:
                                                          1.    CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
                                                          2.    PMT_EDIT_RIC_CD EQUAL 'F'
                                                          3.    CLM_TRANS_CD EQUAL '5'

                                                          SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
                                                          WHERE THE FOLLOWING CONDITIONS ARE MET:
```

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                                        inpatientsnf.txt
                              1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                              2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                              3.   CLM_TRANS_CD EQUAL '0' OR '4'
                              4.   POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
                                   OR 'Z'

                              SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
                              WHERE THE FOLLOWING CONDITIONS ARE MET:
                              1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                              2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                              3.   CLM_TRANS_CD EQUAL '0' OR '4'
                              4.   POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
                                   OR 'Z'
```

```
                                      POSITIONS
            NAME                TYPE  LENGTH BEG  END                          CONTENTS
----------------------------  ----  ------ ---------  ------------------------------------------------------------

                                        SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
                                        WHERE THE FOLLOWING CONDITIONS ARE MET:
                                        1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                                        2.   PMT_EDIT_RIC_CD EQUAL 'D'
                                        3.   CLM_TRANS_CD EQUAL '6'

                                        SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
                                        ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                                        THE FOLLOWING CONDITIONS ARE MET:
                                        1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                                        2.   PMT_EDIT_RIC_CD EQUAL 'D'
                                        3.   CLM_TRANS_CD EQUAL '6'
                                        4.   FI_NUM = 80881

                                        SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
                                        ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
                                        1.   FI_NUM = 80881
                                        2.   CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
                                             CLSFCTN_TYPE_CD = '2', '3' OR '4' &
                                             CLM_FREQ_CD = 'Z', 'Y' OR 'X'

                                        SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
                                        WHERE THE FOLLOWING CONDITIONS ARE MET:
                                        1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
```

inpatientsnf.txt
```
2.    PMT_EDIT_RIC_CD EQUAL 'I'
3.    CLM_TRANS_CD EQUAL 'H'

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1.    CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.    PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3.    CLM_TRANS_CD EQUAL '1' '2' OR '3'

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
1.    CLM_MCO_PD_SW = '1'
2.    CLM_RLT_COND_CD = '04'
3.    MCO_CNTRCT_NUM
      MCO_OPTN_CD = 'C'
      CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
      MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
      ENROLLMENT PERIODS

SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
FOLLOWING CONDITIONS ARE MET:
1.    CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2.    PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3.    CLM_TRANS_CD EQUAL '1' '2' OR '3'
4.    FI_NUM = 80881
```

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                   POSITIONS
          NAME                TYPE  LENGTH BEG  END                                CONTENTS
----------------------------  ----  ------ ---------  ------------------------------------------------------------

                                                      SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
                                                      ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                                                      THE FOLLOWING CONDITIONS ARE MET:
                                                      1.    FI_NUM = 80881 AND
                                                      2.    CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
                                                            TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

                                                      SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
                                                      WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                      1.    CLM_NEAR_LINE_RIC_CD EQUAL 'O'
```

```
                              inpatientsnf.txt
                          2.   HCPCS_CD not on DMEPOS table

                          SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
                          WHERE THE FOLLOWING CONDITIONS ARE MET:
                          1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
                          2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                               more line item(s) match the HCPCS on the
                               DMEPOS table).

                          SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--
                          EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING
                          CONDITIONS ARE MET:
                          1.   CARR_NUM = 80882 AND
                          2.   CLM_DEMO_ID_NUM = 38

                          SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC
                            CLAIM)
                          WHERE THE FOLLOWING CONDITIONS ARE MET:
                          1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                          2.   HCPCS_CD not on DMEPOS table

                          SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
                          WHERE THE FOLLOWING CONDITIONS ARE MET:
                          1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                          2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                               more line item(s) match the HCPCS on the
                               DMEPOS table).

                       CODES:
                         REFER TO: NCH_CLM_TYPE_TB
                                   IN THE CODES APPENDIX

                       SOURCE:
                       NCH

**** Fiscal Intermediary Claim   GROUP   125  59 183  Effective with Version 'I', this group
       Link Group                                     contains those fields necessary to keep records/
                                                      segments together (a claim may have up 10 records/
                                                      segments due to the increase in number of revenue
                                                      center trailers (up to 450).  It is also used to
                                                      house fields necessary for sorting and final
                                                      action processing.

                                                      STANDARD ALIAS: FI_CLM_LINK_GRP
                                      Page 8
```

```
                                       POSITIONS
                NAME           TYPE   LENGTH BEG  END                          CONTENTS
    ---------------------------  ----   ------ ---------   ------------------------------------------------------------

 ****  Claim Locator Number Group  GROUP    11    59   69  This number uniquely identifies the beneficiary in
                                                          the NCH Nearline.

                                                          COMMON ALIAS: HIC
                                                          STANDARD ALIAS: CLM_LCTR_NUM_GRP
                                                          TITLE ALIAS: HICAN

  9. Beneficiary Claim Account   CHAR      9    59   67  The number identifying the primary beneficiary
     Number                                              under the SSA or RRB programs submitted.

                                                          COMMON ALIAS: CAN
                                                          DA3 ALIAS: CLAIM_ACCOUNT_NUMBER
                                                          DB2 ALIAS: BENE_CLM_ACNT_NUM
                                                          SAS ALIAS: CAN
                                                          STANDARD ALIAS: BENE_CLM_ACNT_NUM
                                                          TITLE ALIAS: CAN

                                                          SOURCE:
                                                          SSA,RRB

                                                          LIMITATIONS:
                                                          RRB-issued numbers contain an overpunch in
                                                          the first position that may appear as a plus
                                                          zero or A-G.   RRB-formatted numbers may
                                                          cause matching problems on non-IBM machines.

 10. NCH Category Equatable       CHAR      2    68   69  The code categorizing groups of BICs
     Beneficiary Identification                          representing similar relationships between
     Code                                                the beneficiary and the primary wage earner.

                                                          The equatable BIC module electronically matches
                                                          two records that contain different BICs where
                                                          it is apparent that both are records for the
                                                          same beneficiary.  It validates the BIC and
                                                          returns a base BIC under which to house the
                                                          record in the National Claims History (NCH)
                                                          databases.  (All records for a beneficiary
```

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are stored under a single BIC.)

COMMON ALIAS: NCH_BASE_CATEGORY_BIC
DB2 ALIAS: CTGRY_EQTBL_BIC
SAS ALIAS: EQ_BIC
STANDARD ALIAS: NCH_CTGRY_EQTBL_BIC_CD
TITLE ALIAS: EQUATED_BIC

CODES:
  REFER TO: CTGRY_EQTBL_BENE_IDENT_TB
              IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
CTGRY_EQTBL_BENE_IDENT_CD.

SOURCE:
BIC EQUATE MODULE

			POSITIONS		
NAME	TYPE	LENGTH	BEG	END	CONTENTS
----------------------------	----	------	---------		---
11. Beneficiary Identification Code	CHAR	2	70	71	The code identifying the type of relationship between an individual and a primary Social Security Administration (SSA) beneficiary or a primary Railroad Board (RRB) beneficiary.

COMMON ALIAS: BIC
DA3 ALIAS: BENE_IDENT_CODE
DB2 ALIAS: BENE_IDENT_CD
SAS ALIAS: BIC
STANDARD ALIAS: BENE_IDENT_CD
TITLE ALIAS: BIC

EDIT-RULES:
EDB REQUIRED FIELD

CODES:
  REFER TO: BENE_IDENT_TB
              IN THE CODES APPENDIX

SOURCE:

SSA/RRB

12. NCH State Segment Code   CHAR   1   72   72   The code identifying the segment of the NCH Nearline file
                                                           containing the beneficiary's record for a specific service
                                                           year. Effective 12/96, segmentation is by CLM_LCTR_NUM,
                                                           then final action sequence within residence state. (Prior
                                                           to 12/96, segmentation was by ranges of county codes within
                                                           the residence state.)

                                                           DB2 ALIAS: NCH_STATE_SGMT_CD
                                                           SAS ALIAS: ST_SGMT
                                                           STANDARD ALIAS: NCH_STATE_SGMT_CD
                                                           TITLE ALIAS: NEAR_LINE_SEGMENT

                                                           CODES:
                                                             REFER TO: NCH_STATE_SGMT_TB
                                                                       IN THE CODES APPENDIX

                                                           COMMENT:
                                                           Prior to Version H this field was named:
                                                           BENE_STATE_SGMT_NEAR_LINE_CD.

                                                           SOURCE:
                                                           NCH

13. Beneficiary Residence SSA   CHAR   2   73   74   The SSA standard state code of a beneficiary's residence.
    Standard State Code
                                                           DA3 ALIAS: SSA_STANDARD_STATE_CODE
                                                           DB2 ALIAS: BENE_SSA_STATE_CD
                                                           SAS ALIAS: STATE_CD
                                                           STANDARD ALIAS: BENE_RSDNC_SSA_STD_STATE_CD
                                                           TITLE ALIAS: BENE_STATE_CD

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                                              POSITIONS
              NAME   TYPE   LENGTH BEG   END   CONTENTS
    ----------------------------   ----   ------ ---------   --

                                                           EDIT-RULES:
                                                           OPTIONAL: MAY BE BLANK

                                                           CODES:
                                                             REFER TO: GEO_SSA_STATE_TB

COMMENT:
1. Used in conjunction with a county code, as
   selection criteria for the determination of
   payment rates for HMO reimbursement.
2. Concerning individuals directly billable for
   Part B and/or Part A premiums, this element
   is used to determine if the beneficiary
   will receive a bill in English or Spanish.
3. Also used for special studies.

SOURCE:
SSA/EDB

14. Claim From Date	NUM	8	75	82	The first day on the billing statement covering services rendered to the bene-ficiary (a.k.a. 'Statement Covers From Date').

NOTE: For Home Health PPS claims, the 'from'
date and the 'thru' date on the RAP (initial
claim) must always match.

8 DIGITS UNSIGNED

DB2 ALIAS: CLM_FROM_DT
SAS ALIAS: FROM_DT
STANDARD ALIAS: CLM_FROM_DT
TITLE ALIAS: FROM_DATE

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

15. Claim Through Date	NUM	8	83	90	The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date').

NOTE: For Home Health PPS claims, the 'from'
date and the 'thru' date on the RAP (initial
claim) must always match.

8 DIGITS UNSIGNED

DB2 ALIAS: CLM_THRU_DT
SAS ALIAS: THRU_DT
STANDARD ALIAS: CLM_THRU_DT
TITLE ALIAS: THRU_DATE

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                      POSITIONS
              NAME            TYPE  LENGTH BEG  END                          CONTENTS
   --------------------------  ----  ------ ---------  ------------------------------------------------------------
```

                                                      EDIT-RULES:
                                                      YYYYMMDD

                                                      SOURCE:
                                                      CWF

   16. NCH Weekly Claim Processing NUM   8   91   98   The date the weekly NCH database load
       Date   process cycle begins, during which the claim
                                                           records are loaded into the Nearline file.
                                                           This date will always be a Friday, although
                                                           the claims will actually be appended to the
                                                           database subsequent to the date.

                                                      8 DIGITS UNSIGNED

                                                      DB2 ALIAS: NCH_WKLY_PROC_DT
                                                      SAS ALIAS: WKLY_DT
                                                      STANDARD ALIAS: NCH_WKLY_PROC_DT
                                                      TITLE ALIAS: NCH_PROCESS_DT

                                                      EDIT-RULES:
                                                      YYYYMMDD

                                                      COMMENT:
                                                      Prior to Version H this field was named:
                                                      HCFA_CLM_PROC_DT.

                                                      SOURCE:
                                                      NCH

   17. CWF Claim Accretion Date   NUM   8   99 106   The date the claim record is accreted (posted/
                                                         processed) to the beneficiary master record

at the CWF host site and authorization for
payment is returned to the fiscal interme-
diary or carrier.

8 DIGITS UNSIGNED

DB2 ALIAS: CWF_CLM_ACRTN_DT
SAS ALIAS: ACRTN_DT
STANDARD ALIAS: CWF_CLM_ACRTN_DT
TITLE ALIAS: ACCRETION_DT

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

| | | | POSITIONS | | |
NAME	TYPE	LENGTH	BEG	END	CONTENTS

18. CWF Claim Accretion Number   PACK   2   107 108 The sequence number assigned to the claim
                                                          record when accreted (posted/processed) to
                                                          the beneficiary master record at the CWF host
                                                          site on a given date. This element indicates
                                                          the position of the claim within that day's
                                                          processing at the CWF host. **(Exception: If
                                                          the claim record is missing the accretion date
                                                          HCFA's CWFMQA system places a zero in the
                                                          accretion number.

                                                          3 DIGITS SIGNED

                                                          DB2 ALIAS: CWF_CLM_ACRTN_NUM
                                                          SAS ALIAS: ACRTN_NM
                                                          STANDARD ALIAS: CWF_CLM_ACRTN_NUM
                                                          TITLE ALIAS: ACCRETION_NUMBER

                                                          SOURCE:
                                                          CWF

19. FI Document Claim Control   CHAR   23   109 131 Unique control number assigned by an

intermediary to an institutional claim.

COMMON ALIAS: ICN
DB2 ALIAS: DOC_CLM_CNTL_NUM
SAS ALIAS: CLM_CNTL
STANDARD ALIAS: FI_DOC_CLM_CNTL_NUM
TITLE ALIAS: ICN

SOURCE:
CWF

20. FI Original Claim Control   CHAR   23   132 154   Effective with Version G, the original intermediary
    Number   control number (ICN) which is present on adjustment
                                                         claims, representing the ICN of the original
                                                         transaction now being adjusted.

COMMON ALIAS: ORIGINAL_ICN
DB2 ALIAS: ORIG_CLM_CNTL_NUM
SAS ALIAS: ORIGCNTL
STANDARD ALIAS: FI_ORIG_CLM_CNTL_NUM
TITLE ALIAS: ORIGINAL_ICN

SOURCE:
CWF

21. Claim Query Code   CHAR   1   155 155   Code indicating the type of claim record being processed
                                                         with respect to payment (debit/credit indicator;
                                                         interim/final indicator).

DB2 ALIAS: CLM_QUERY_CD
SAS ALIAS: QUERY_CD
STANDARD ALIAS: CLM_QUERY_CD
TITLE ALIAS: QUERY_CD

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                          POSITIONS
          NAME   TYPE LENGTH BEG END   CONTENTS
--------------------------- ---- ------ --------- --

CODES:
0 = Credit adjustment
1 = Interim bill
2 = Home Health Agency (HHA) benefits
    exhausted (obsolete 7/98)

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                             inpatientsnf.txt
                         3 = Final bill
                         4 = Discharge notice (obsolete 7/98)
                         5 = Debit adjustment

                         SOURCE:
                         CWF

22. Provider Number          CHAR    6   156  161   The identification number of the institutional provider
                                                    certified by Medicare to provide services to the
                                                    beneficiary.

                                                    DB2 ALIAS: PRVDR_NUM
                                                    SAS ALIAS: PROVIDER
                                                    STANDARD ALIAS: PRVDR_NUM
                                                    TITLE ALIAS: PROVIDER_NUMBER

                                                    CODES:
                                                      REFER TO: PRVDR_NUM_TB
                                                                IN THE CODES APPENDIX

                                                    SOURCE:
                                                    OSCAR

23. NCH Daily Process Date    NUM     8   162  169   Effective with Version H, the date the claim record was
                                                     processed by HCFA's CWFMQA system (used for internal editing
                                                     purposes).

                                                     Effective with Version I, this date is used in conjunction
                                                     with the NCH Segment Link Number to keep claims with
                                                     multiple records/ segments together.

                                                     NOTE1:  With Version 'H' this field was pop- ulated with
                                                             data beginning with NCH weekly process date 10/3/97.
                                                             Under Version 'I' claims prior to 10/3/97, that were
                                                             blank under Version 'H', were populated with a date.

                                                     8 DIGITS UNSIGNED

                                                     DB2 ALIAS: NCH_DAILY_PROC_DT
                                                     SAS ALIAS: DAILY_DT
                                                     STANDARD ALIAS: NCH_DAILY_PROC_DT
                                                     TITLE ALIAS: DAILY_PROCESS_DT

                                                     EDIT-RULES:
```

YYYYMMDD

SOURCE:
NCH

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                      POSITIONS
            NAME               TYPE  LENGTH BEG   END                          CONTENTS
------------------------------ ----  ------ --------  ------------------------------------------------------------
```

24. NCH Segment Link Number   PACK   5   170 174   Effective with Version 'I', the system gen-
                                                      erated number used in conjunction with the
                                                      NCH daily process date to keep records/segments
                                                      belonging to a specific claim together.
                                                      This field was added to ensure that records/
                                                      segments that come in on the same batch with
                                                      the same identifying information in the link
                                                      group are not mixed with each other.

                                                      NOTE: During the Version I conversion this
                                                              field was populated with data throughout
                                                              history (back to service year 1991).

                                                      9 DIGITS SIGNED

                                                      DB2 ALIAS: NCH_SGMT_LINK_NUM
                                                      SAS ALIAS: LINK_NUM
                                                      STANDARD ALIAS: NCH_SGMT_LINK_NUM
                                                      TITLE ALIAS: LINK_NUM

                                                      SOURCE:
                                                      NCH

25. Claim Total Segment Count   NUM   2   175 176   Effective with Version I, the count used
                                                      to identify the total number of segments
                                                      associated with a given claim. Each claim
                                                      could have up to 10 segments.

                                                      NOTE: During the Version I conversion, this
                                                              field was populated with data throughout
                                                              history (back to service year 1991).
                                                              For institutional claims, the count
                                                              for claims prior to 7/00 will be 1 or 2

inpatientsnf.txt
(1 if 45 or less revenue center lines on a
claim and 2 if more than 45 revenue center
lines on a claim). For noninstitutional
claims, the count will always be 1.

2 DIGITS UNSIGNED

DB2 ALIAS: TOT_SGMT_CNT
SAS ALIAS: SGMT_CNT
STANDARD ALIAS: CLM_TOT_SGMT_CNT
TITLE ALIAS: SEGMENT_COUNT

SOURCE:
CWF

26. Claim Segment Number   NUM   2   177 178   Effective with Version I, the number used
                                                         to identify an actual record/segment (1 - 10)
                                                         associated with a given claim.

                                          POSITIONS
            NAME   TYPE LENGTH BEG END   CONTENTS
---------------------------- ---- ------ --------- --

                                                   NOTE: During the Version I conversion this
                                                          field was populated with data throughout
                                                          history (back to service year 1991).
                                                          For institutional claims prior to 7/00,
                                                          this number will be either 1 or 2. For
                                                          noninstitutional claims, the number will
                                                          always be 1.

                                                   2 DIGITS UNSIGNED

                                                   DB2 ALIAS: CLM_SGMT_NUM
                                                   SAS ALIAS: SGMT_NUM
                                                   STANDARD ALIAS: CLM_SGMT_NUM
                                                   TITLE ALIAS: SEGMENT_NUMBER

                                                   SOURCE:
                                                   CWF

27. Claim Total Line Count   NUM   3   179 181   Effective with Version I, the count used to

```
                               inpatientsnf.txt
                        identify the total number of revenue center
                        lines associated with the claim.

                        NOTE:   During the Version I conversion this
                                field was populated with data throughout
                                history (back to service year 1991).
                                Prior to Version 'I', the maximum line count
                                will be no more than 58.  Effective with Version
                                'I', the maximum line count could be 450.

                        3 DIGITS UNSIGNED

                        DB2 ALIAS: TOT_LINE_CNT
                        SAS ALIAS: LINECNT
                        STANDARD ALIAS: CLM_TOT_LINE_CNT
                        TITLE ALIAS: TOTAL_LINE_COUNT

                        SOURCE:
                        CWF

  28. Claim Segment Line Count     NUM      2   182  183  Effective with Version I, the count used
                                                          to identify the number of revenue center
                                                          lines on a record/segment.

                        NOTE:   During the Version I conversion this
                                field was populated with data throughout
                                history (back to service year 1991).
                                The maximum line count per record/segment
                                is 45.

                        2 DIGITS UNSIGNED

                        DB2 ALIAS: SGMT_LINE_CNT
                        SAS ALIAS: SGMTLINE
                        STANDARD ALIAS: CLM_SGMT_LINE_CNT
                        TITLE ALIAS: SEGMENT_LINE_COUNT
```

```
                                        POSITIONS
                NAME              TYPE   LENGTH BEG   END                        CONTENTS
        ---------------------------    ----   ------ ---------   -------------------------------------------------------------

                        SOURCE:
                        CWF
```

```
****  FI Claim Common Group        GROUP   359   184   542   Information common to fiscal intermediary (FI)
                                                            claims (inpatient/SNF, outpatient, HHA & hospice),
                                                            for version I of NCH Nearline file.

                                                            STANDARD ALIAS: FI_CLM_CMN_GRP

  29. NCH Payment and Edit Record   CHAR    1     184   184   The code used for payment and editing purposes that
      Identification Code                                     indicates the type of institutional claim record.

                                                            DB2 ALIAS: PMT_EDIT_RIC_CD
                                                            SAS ALIAS: PE_RIC
                                                            STANDARD ALIAS: NCH_PMT_EDIT_RIC_CD
                                                            TITLE ALIAS: NCH_PAYMENT_EDIT_RIC

                                                            CODES:
                                                            C = Inpatient hospital, SNF
                                                            D = Outpatient
                                                            E = Religious Nonmedical Health Care Institutions (eff. 8/00
                                                                Christian Science, prior to 7/00
                                                            F = Home Health Agency (HHA)
                                                            G = Discharge notice
                                                                (obsoleted 7/98)
                                                            I = Hospice

                                                            COMMENT:
                                                            Prior to Version H this field was named:
                                                            PMT_EDIT_RIC_CD.

                                                            SOURCE:
                                                            NCH QA Process

  30. Claim Transaction Code        CHAR    1     185   185   The code derived by CWF to indicate the type of claim
                                                            submitted by an institutional provider.

                                                            DB2 ALIAS: CLM_TRANS_CD
                                                            SAS ALIAS: TRANS_CD
                                                            STANDARD ALIAS: CLM_TRANS_CD
                                                            SYSTEM ALIAS: LTCLTRAN
                                                            TITLE ALIAS: TRANSACTION_CODE

                                                            CODES:
                                                              REFER TO: CLM_TRANS_TB
                                                                      IN THE CODES APPENDIX
```

```
                                        SOURCE:
                                        CWF

 ****  Claim Bill Type Group      GROUP    2   186  187  Effective with Version H, the claim facility type code plus
                                                         the claim service classification type code.  (The first two
                                                         positions of the ('type of bill').  During the Version H
                                                         conversion, this grouping was created throughout history.
1                    FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                            POSITIONS
             NAME               TYPE  LENGTH BEG  END                        CONTENTS
    ---------------------------  ----  ------ ---------  ------------------------------------------------------------
                                                        STANDARD ALIAS: CLM_BILL_TYPE_CD_GRP
                                                        SYSTEM ALIAS: LTBILLCD

                                                        CODES:
                                                           REFER TO: CLM_BILL_TYPE_TB
                                                                     IN THE CODES APPENDIX

   31. Claim Facility Type Code  CHAR     1   186  186  The first digit of the type of bill (TOB1) submitted on an
                                                        institutional claim used to identify the type of facility
                                                        that provided care to the beneficiary.

                                                        COMMON ALIAS: TOB1
                                                        DB2 ALIAS: CLM_FAC_TYPE_CD
                                                        SAS ALIAS: FAC_TYPE
                                                        STANDARD ALIAS: CLM_FAC_TYPE_CD
                                                        TITLE ALIAS: TOB1

                                                        CODES:
                                                           REFER TO: CLM_FAC_TYPE_TB
                                                                     IN THE CODES APPENDIX

                                                        SOURCE:
                                                        CWF

   32. Claim Service             CHAR     1   187  187  The second digit of the type of bill (TOB2) submitted on an
       Classification Type Code                         institutional claim record to indicate the classification of
                                                        the type of service provided to the beneficiary.

                                                        COMMON ALIAS: TOB2
                                                        DB2 ALIAS: SRVC_CLSFCTN_CD
```

```
                                inpatientsnf.txt
                                SAS ALIAS: TYPESRVC
                                STANDARD ALIAS: CLM_SRVC_CLSFCTN_TYPE_CD
                                TITLE ALIAS: TOB2


                                CODES:
                                  REFER TO: CLM_SRVC_CLSFCTN_TYPE_TB
                                            IN THE CODES APPENDIX


                                SOURCE:
                                CWF

  33. Claim Frequency Code      CHAR     1   188  188   The third digit of the type of bill (TOB3) submitted on an
                                                        institutional claim record to indicate the sequence of a
                                                        claim in the beneficiary's current episode of care.


                                COMMON ALIAS: TOB3
                                DB2 ALIAS: CLM_FREQ_CD
                                SAS ALIAS: FREQ_CD
                                STANDARD ALIAS: CLM_FREQ_CD
                                SYSTEM ALIAS: LTFREQ
                                TITLE ALIAS: FREQUENCY_CD


                                CODES:
                                  REFER TO: CLM_FREQ_TB
                                            IN THE CODES APPENDIX
1                FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002


                                           POSITIONS
            NAME                  TYPE  LENGTH BEG   END                           CONTENTS
    ---------------------------   ----  ------ ---------  ----------------------------------------------------------

                                SOURCE:
                                CWF

  34. FILLER                     CHAR     1   189  189

  35. NCH MQA Query Patch Code   CHAR     1   190  190   Effective with Version H, a code used (for internal editing
                                                        purposes) to indicate that the CWFMQA process changed the
                                                        query code submitted on the claim record.

                                NOTE:  Beginning with NCH weekly process date 10/3/97 this
                                       field was populated with data.  Claims processed
                                       prior to 10/3/97 will contain spaces in this field.


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```

```
                                    inpatientsnf.txt
                        DB2 ALIAS: MQA_QUERY_PATCH_CD
                        SAS ALIAS: MQAQUERY
                        STANDARD ALIAS: NCH_MQA_QUERY_PATCH_CD
                        TITLE ALIAS: MQA_QUERY_PATCH_IND

                        CODES:
                        Y = MQA changed bill query code on a action
                            code 6 (force action code 2)
                            bill to a zero. (Eff. 10/12/93)
                        Z = MQA changed bill query code on a action
                            code 4 (cancel only adjustment)
                            bill to zero.  (Eff. 5/16/94)

                        SOURCE:
                        NCH QA Process

  36. Claim Disposition Code      CHAR    2   191  192   Code indicating the disposition or outcome of the processing
                                                         of the claim record.

                                                         DB2 ALIAS: CLM_DISP_CD
                                                         SAS ALIAS: DISP_CD
                                                         STANDARD ALIAS: CLM_DISP_CD
                                                         TITLE ALIAS: DISPOSITION_CD

                                                         CODES:
                                                           REFER TO: CLM_DISP_TB
                                                                     IN THE CODES APPENDIX

                                                         SOURCE:
                                                         CWF

  37. NCH Edit Disposition Code   CHAR    2   193  194   Effective with Version H, a code used (for internal editing
                                                         purposes) to indicate the disposition of the claim after
                                                         editing in the CWFMQA process.

                                                         NOTE:   Beginning with NCH weekly process date 10/3/97 this
                                                                 field was populated with data. Claims processed prior
                                                                 to 10/3/97 will contain spaces in this field.
```

```
                                             POSITIONS
                NAME              TYPE  LENGTH BEG   END                        CONTENTS
        ----------------------------  ----  ------ ---------  -------------------------------------------------------------
```

```
DB2 ALIAS: NCH_EDIT_DISP_CD
SAS ALIAS: EDITDISP
STANDARD ALIAS: NCH_EDIT_DISP_CD
TITLE ALIAS: NCH_EDIT_DISP

CODES:
00 = No MQA errors
10 = Possible duplicate
20 = Utilization error
30 = Consistency error
40 = Entitlement error
50 = Identification error
60 = Logical duplicate
70 = Systems duplicate

SOURCE:
NCH QA Process
```

38. NCH Claim BIC Modify H Code CHAR   1   195 195   Effective with Version H, the code used (for internal editing purposes) to identify a claim record that was submitted with an incorrect HA, HB, or HC BIC.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data.   Claims processed prior to 10/3/97 will contain spaces in this field.

```
DB2 ALIAS: NCH_BIC_MDFY_CD
SAS ALIAS: BIC_MDFY
STANDARD ALIAS: NCH_CLM_BIC_MDFY_CD
TITLE ALIAS: BIC_MODIFY_CD

CODES:
H = BIC submitted by CWF = HA, HB or HC
blank = No HA, HB or HC BIC present

SOURCE:
NCH QA Process
```

39. Beneficiary Residence SSA   CHAR   3   196 198   The SSA standard county code of a beneficiary's residence.
    Standard County Code

```
DA3 ALIAS: SSA_STANDARD_COUNTY_CODE
DB2 ALIAS: BENE_SSA_CNTY_CD
SAS ALIAS: CNTY_CD
```

inpatientsnf.txt
                        STANDARD ALIAS: BENE_RSDNC_SSA_STD_CNTY_CD
                        TITLE ALIAS: BENE_COUNTY_CD

                        EDIT-RULES:
                        OPTIONAL: MAY BE BLANK

                        SOURCE:
                        SSA/EDB

    40. FI Claim Receipt Date   NUM   8   199 206 The date the fiscal intermediary received the
                                                            institutional claim from the provider.

                                           POSITIONS
              NAME   TYPE LENGTH BEG END   CONTENTS
    ---------------------------   ---- ------ --------- ---

                                                         8 DIGITS UNSIGNED

                                                         DB2 ALIAS: FI_CLM_RCPT_DT
                                                         SAS ALIAS: RCPT_DT
                                                         STANDARD ALIAS: FI_CLM_RCPT_DT
                                                         TITLE ALIAS: RECEIPT_DT

                                                         EDIT-RULES:
                                                         YYYYMMDD

                                                         COMMENT:
                                                         Prior to Version H this field was named:
                                                         FICARR_CLM_RCPT_DT.

                                                         SOURCE:
                                                         CWF

    41. FI Claim Scheduled Payment   NUM   8   207 214 The scheduled date of payment to the institu-
        Date   tional provider, as reflected on the claim
                                                            record transmitted to the CWF host. Note:
                                                            This date is considered to be the date paid
                                                            since no additional information as to the
                                                            actual payment date is available.

                                                         8 DIGITS UNSIGNED

DB2 ALIAS: FI_SCHLD_PMT_DT
SAS ALIAS: SCHLD_DT
STANDARD ALIAS: FI_CLM_SCHLD_PMT_DT
TITLE ALIAS: SCHEDULED_PMT_DT

EDIT-RULES:
YYYYMMDD

COMMENT:
Prior to Version H this field was named:
FICARR_CLM_PMT_DT.

SOURCE:
CWF

42. CWF Forwarded Date   NUM   8   215 222   Effective with Version H, the date CWF forwarded the claim
                                                          record to HCFA (used for internal editing purposes).

                                                          NOTE: Beginning with NCH weekly process date 10/3/97 this
                                                                  field was populated with data. Claims processed
                                                                  prior to 10/3/97 will contain zeroes in this field.

                                                          8 DIGITS UNSIGNED

                                                          DB2 ALIAS: CWF_FRWRD_DT
                                                          SAS ALIAS: FRWRD_DT
                                                          STANDARD ALIAS: CWF_FRWRD_DT
                                                          TITLE ALIAS: FORWARD_DT

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| | | | POSITIONS | | |
NAME	TYPE	LENGTH	BEG	END	CONTENTS

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

43. FI Number   CHAR   5   223 227   The identification number assigned by HCFA to a fiscal
                                                          intermediary authorized to process institutional claim
                                                          records.

DB2 ALIAS: FI_NUM
SAS ALIAS: FI_NUM
STANDARD ALIAS: FI_NUM
SYSTEM ALIAS: LTFI
TITLE ALIAS: INTERMEDIARY

CODES:
  REFER TO: FI_NUM_TB
             IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
FICARR_IDENT_NUM.

SOURCE:
CWF

44. CWF Claim Assigned Number   CHAR   8 228 235   Effective with Version H, the number assigned
to an institutional claim record by CWF (used
for internal editing purposes).

NOTE: Beginning with NCH weekly process date
       10/3/97 this field was populated with
       data. Claims processed prior to 10/3/97
       will contain spaces in this field.

DB2 ALIAS: CWF_CLM_ASGN_NUM
SAS ALIAS: ASGN_NUM
STANDARD ALIAS: CWF_CLM_ASGN_NUM
TITLE ALIAS: ASSIGNED_NUM

SOURCE:
CWF

45. CWF Transmission Batch   CHAR   4 236 239   Effective with Version H, the number assigned
   Number   to each batch of claims transactions sent from
CWF(used for internal editing purposes).

NOTE: Beginning 11/98, this field will be
       populated with data. Claims processed
       prior to 11/98 will contain spaces in
       this field.

```
                                           POSITIONS
              NAME               TYPE  LENGTH BEG  END                           CONTENTS
    ----------------------------  ----  ------ ---------  -----------------------------------------------------------
                                                          DB2 ALIAS: TRNSMSN_BATCH_NUM
                                                          SAS ALIAS: FIBATCH
                                                          STANDARD ALIAS: CWF_TRNSMSN_BATCH_NUM
                                                          TITLE ALIAS: BATCH_NUM

                                                          SOURCE:
                                                          CWF

    46. Beneficiary Mailing Contact  CHAR    9   240  248  The ZIP code of the mailing address where the
        ZIP Code                                           beneficiary may be contacted.

                                                          DB2 ALIAS: BENE_MLG_ZIP_CD
                                                          SAS ALIAS: BENE_ZIP
                                                          STANDARD ALIAS: BENE_MLG_CNTCT_ZIP_CD
                                                          TITLE ALIAS: BENE_ZIP

                                                          SOURCE:
                                                          EDB

    47. Beneficiary Sex              CHAR    1   249  249  The sex of a beneficiary.
        Identification Code
                                                          COMMON ALIAS: SEX_CD
                                                          DA3 ALIAS: SEX_CODE
                                                          DB2 ALIAS: BENE_SEX_IDENT_CD
                                                          SAS ALIAS: SEX
                                                          STANDARD ALIAS: BENE_SEX_IDENT_CD
                                                          SYSTEM ALIAS: LTSEX
                                                          TITLE ALIAS: SEX_CD

                                                          EDIT-RULES:
                                                          REQUIRED FIELD

                                                          CODES:
                                                          1 = Male
                                                          2 = Female
                                                          0 = Unknown

                                                          SOURCE:
```

                          SSA,RRB,EDB

    48. Beneficiary Race Code   CHAR   1   250   250 The race of a beneficiary.

                                                              DA3 ALIAS: RACE_CODE
                                                              DB2 ALIAS: BENE_RACE_CD
                                                              SAS ALIAS: RACE
                                                              STANDARD ALIAS: BENE_RACE_CD
                                                              SYSTEM ALIAS: LTRACE
                                                              TITLE ALIAS: RACE_CD

                                                              CODES:
                                                              0 = Unknown
                                                              1 = White
                                                              2 = Black
                                                              3 = Other
1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                     POSITIONS
            NAME   TYPE LENGTH BEG END   CONTENTS
    --------------------------- ---- ------ --------- --

                                                              4 = Asian
                                                              5 = Hispanic
                                                              6 = North American Native

                                                              SOURCE:
                                                              SSA

    49. Beneficiary Birth Date   NUM   8   251   258 The beneficiary's date of birth.

                                                              8 DIGITS UNSIGNED

                                                              DB2 ALIAS: BENE_BIRTH_DT
                                                              SAS ALIAS: BENE_DOB
                                                              STANDARD ALIAS: BENE_BIRTH_DT
                                                              TITLE ALIAS: BENE_BIRTH_DATE

                                                              EDIT-RULES:
                                                              YYYYMMDD

                                                              SOURCE:
                                                              CWF

50. CWF Beneficiary Medicare   CHAR   2   259 260   The CWF-derived reason for a beneficiary's
    Status Code   entitlement to Medicare benefits, as of the
                                                         reference date (CLM_THRU_DT).

                                                         COBOL ALIAS: MSC
                                                         COMMON ALIAS: MSC
                                                         DB2 ALIAS: BENE_MDCR_STUS_CD
                                                         SAS ALIAS: MS_CD
                                                         STANDARD ALIAS: CWF_BENE_MDCR_STUS_CD
                                                         SYSTEM ALIAS: LTMSC
                                                         TITLE ALIAS: MSC

                                                         DERIVATION:
                                                         CWF derives MSC from the following:
                                                           1. Date of Birth
                                                           2. Claim Through Date
                                                           3. Original/Current Reasons for entitlement
                                                           4. ESRD Indicator
                                                           5. Beneficiary Claim Number
                                                         Items 1,3,4,5 come from the CWF Beneficiary
                                                         Master Record; item 2 comes from the FI/Carrier
                                                         claim record. MSC is assigned as follows:

MSC	OASI	DIB	ESRD	AGE	BIC
10	YES	N/A	NO	65 and over	N/A
11	YES	N/A	YES	65 and over	N/A
20	NO	YES	NO	under 65	N/A
21	NO	YES	YES	under 65	N/A
31	NO	NO	YES	any age	T.

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                                   POSITIONS
              NAME   TYPE LENGTH BEG END   CONTENTS
    ---------------------------- ---- ------ --------- ---

                                                         CODES:
                                                         10 = Aged without ESRD
                                                         11 = Aged with ESRD
                                                         20 = Disabled without ESRD
                                                         21 = Disabled with ESRD
                                                         31 = ESRD only

                                                  Page 30

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COMMENT:
Prior to Version H this field was named:
BENE_MDCR_STUS_CD. The name has been changed
to distinguish this CWF-derived field from the
EDB-derived MSC (BENE_MDCR_STUS_CD).

SOURCE:
CWF

51. Claim Patient 6 Position   CHAR   6   261 266   The first 6 positions of the Medicare patient's
    Surname   surname (last name) as reported by the provider
                                                        on the claim.

                                                        NOTE1: Prior to Version H, this field was only
                                                               present on the IP/SNF claim record.
                                                               Effective with Version H, this field is
                                                               present on all claim types.

                                                        NOTE2: For OP, HHA, Hospice and all Carrier
                                                               claims, data was populated beginning
                                                               with NCH weekly process 10/3/97. Claims
                                                               processed prior to 10/3/97 will contain
                                                               spaces in this field.

                                                        COMMON ALIAS: PATIENT_SURNAME
                                                        DB2 ALIAS: PTNT_6_PSTN_SRNM
                                                        SAS ALIAS: SURNAME
                                                        STANDARD ALIAS: CLM_PTNT_6_PSTN_SRNM_NAME
                                                        TITLE ALIAS: PATIENT_SURNAME

                                                        SOURCE:
                                                        CWF

52. Claim Patient 1st Initial   CHAR   1   267 267   The first initial of the Medicare patient's
    Given Name   given name (first name) as reported by the
                                                        provider on the claim.

                                                        NOTE1: Prior to Version H, this field was only
                                                               present on the IP/SNF claim record.
                                                               Effective with Version H, this field
                                                               is present on all claim types.

                                                        NOTE2: For OP, HHA, Hospice and all Carrier claims,
                                                               data was populated beginning with NCH

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                                                            inpatientsnf.txt
                                                            weekly process date 10/3/97.  Claims
                                                            processed prior to 10/3/97 will contain
                                                            spaces in this field.
```

```
                                          POSITIONS
            NAME                TYPE  LENGTH BEG  END                           CONTENTS
    ----------------------------  ----  ------ ---------  ------------------------------------------------------------
```

```
                                                            COMMON ALIAS: PATIENT_GIVEN_NAME
                                                            DB2 ALIAS: 1ST_INITL_GVN_NAME
                                                            SAS ALIAS: FRSTINIT
                                                            STANDARD ALIAS: CLM_PTNT_1ST_INITL_GVN_NAME
                                                            TITLE ALIAS: PATIENT_FIRST_INITIAL
```

```
                                                            SOURCE:
                                                            CWF
```

```
    53. Claim Patient First Initial  CHAR   1    268  268  The first initial of the Medicare patient's
        Middle Name                                         middle name as reported by the provider on
                                                            the claim.
```

```
                                                            NOTE1:   Prior to Version H, this field was only
                                                                     present on the IP/SNF claim record.
                                                                     Effective with Version H, this field is
                                                                     present on all claim types.
```

```
                                                            NOTE2:   For OP, HHA, Hospice and all Carrier claims,
                                                                     data was populated beginning with NCH
                                                                     weekly process date 10/3/97.   Claims pro-
                                                                     cessed prior to 10/3/97 will contain
                                                                     spaces in this field.
```

```
                                                            COMMON ALIAS: PATIENT_MIDDLE_NAME
                                                            DB2 ALIAS: 1ST_INITL_MDL_NAME
                                                            SAS ALIAS: MDL_INIT
                                                            STANDARD ALIAS: CLM_PTNT_1ST_INITL_MDL_NAME
                                                            TITLE ALIAS: PATIENT_MIDDLE_INITIAL
```

```
                                                            SOURCE:
                                                            CWF
```

```
    54. Beneficiary CWF Location     CHAR   1    269  269  The code that identifies the Common Working File
```

                     Code   (CWF) location (the host site) where a beneficiary's
                                                   Medicare utilization records are maintained.

                                                   COMMON ALIAS: CWF_HOST
                                                   DB2 ALIAS: BENE_CWF_LOC_CD
                                                   SAS ALIAS: CWFLOCCD
                                                   STANDARD ALIAS: BENE_CWF_LOC_CD
                                                   SYSTEM ALIAS: LTCWFLOC
                                                   TITLE ALIAS: CWF_HOST

                                                   CODES:
                                                   B = Mid-Atlantic
                                                   C = Southwest
                                                   D = Northeast
                                                   E = Great Lakes
                                                   F = Great Western
                                                   G = Keystone
                                                   H = Southeast
                                                   I = South
                                                   J = Pacific

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                                        POSITIONS
              NAME   TYPE LENGTH BEG END   CONTENTS
    ---------------------------- ---- ------ --------- ---

                                                   SOURCE:
                                                   CWF

  55. Claim Principal Diagnosis   CHAR   5   270 274   The ICD-9-CM diagnosis code identifying the diagnosis,
      Code   condition, problem or other reason for the
                                                           admission/encounter/visit shown in the medical record to be
                                                           chiefly responsible for the services provided.

                                                           NOTE: Effective with Version H, this data is also
                                                           redundantly stored as the first occurrence of the diagnosis
                                                           trailer.

                                                           DB2 ALIAS: PRNCPAL_DGNS_CD
                                                           SAS ALIAS: PDGNS_CD
                                                           STANDARD ALIAS: CLM_PRNCPAL_DGNS_CD
                                                           TITLE ALIAS: PRINCIPAL_DIAGNOSIS

```
                              inpatientsnf.txt
                              EDIT-RULES:
                              ICD-9-CM

                              SOURCE:
                              CWF

    56. FILLER                    CHAR    1   275  275

    57. Claim Medicare Non Payment  CHAR    1   276  276   The reason that no Medicare payment is made for
        Reason Code                                        services on an institutional claim.

                                                           NOTE:  Effective with Version I, this field was
                                                                  put on all institutional claim types.
                                                                  Prior to Version I, this field was present
                                                                  only on inpatient/SNF claims.

                                                           DB2 ALIAS: MDCR_NPMT_RSN_CD
                                                           SAS ALIAS: NOPAY_CD
                                                           STANDARD ALIAS: CLM_MDCR_NPMT_RSN_CD
                                                           SYSTEM ALIAS: LTNPMT
                                                           TITLE ALIAS: NON_PAYMENT_REASON

                                                           EDIT-RULES:
                                                           OPTIONAL

                                                           CODES:
                                                             REFER TO: CLM_MDCR_NPMT_RSN_TB
                                                                       IN THE CODES APPENDIX

                                                           SOURCE:
                                                           CWF
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                                   POSITIONS
            NAME              TYPE  LENGTH BEG  END                         CONTENTS
    --------------------------- ---- ------ --------  -----------------------------------------------------------

    58. Claim Excepted/Nonexcepted  CHAR    1   277  277   Effective with Version I, the code used to identify
        Medical Treatment Code                             whether or not the medical care or treatment received
                                                           by a beneficiary, who has elected care from a
                                                           Religious Nonmedical Health Care Institution (RNHCI),
                                                           is excepted or nonexcepted.  Excepted is medical care
                                                           or treatment that is received involuntarily or is re-
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quired under Federal, State or local law. Nonexcepted is
defined as medical care or treatment other than excepted.

DB2 ALIAS: EXCPTD_NEXCPTD_CD
SAS ALIAS: TRTMT_CD
STANDARD ALIAS: CLM_EXCPTD_NEXCPTD_TRTMT_CD
TITLE ALIAS: EXCPTD_NEXCPTD_CD

CODES:
0 = No Entry
1 = Excepted
2 = Nonexcepted

SOURCE:
CWF

59. Claim Payment Amount   PACK   6   278 283   Amount of payment made from the Medicare trust fund for the
                                                           services covered by the claim record. Generally, the amount
                                                           is calculated by the FI or carrier; and represents what was
                                                           paid to the institutional provider, physician, or supplier,
                                                           with the exceptions noted below. **NOTE: In some
                                                           situations, a negative claim payment amount may be pre-
                                                           sent; e.g., (1) when a beneficiary is charged the full
                                                           deductible during a short stay and the deductible exceeded
                                                           the amount Medicare pays; or (2) when a beneficiary is
                                                           charged a coinsurance amount during a long stay and the
                                                           coinsurance amount exceeds the amount Medicare pays (most
                                                           prevalent situation involves psych hospitals who are paid a
                                                           daily per diem rate no matter what the charges are.)

                                                           Under IP PPS, inpatient hospital services are paid based on
                                                           a predetermined rate per discharge, using the DRG patient
                                                           classification system and the PRICER program. On the IP
                                                           PPS claim, the payment amount includes the DRG outlier
                                                           approved payment amount, disproportionate share (since
                                                           5/1/86), indirect medical education (since 10/1/88), total
                                                           PPS capital (since 10/1/91). It does NOT include the pass
                                                           thru amounts (i.e., capital-related costs, direct medical
                                                           education costs, kidney acquisition costs, bad debts); or
                                                           any beneficiary-paid amounts (i.e., deductibles and
                                                           coinsurance); or any other payer reimbursement.

                                                           Under SNF PPS, SNFs will classify beneficiaries using the
                                                           patient classification system known as RUGS III. For the

SNF PPS claim, the SNF PRICER will calculate/return the rate
for each revenue center line item with revenue center code =
'0022'; multiply the rate times the units count; and then
sum the amount payable for all lines with revenue center
code '0022' to determine the total claim payment amount.

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                                          POSITIONS
             NAME                 TYPE   LENGTH BEG   END                           CONTENTS
     ----------------------------  ----   ------ ---------   ------------------------------------------------------------
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Under Outpatient PPS, the national ambulatory payment
classification (APC) rate that is calculated for each APC
group is the basis for determining the total payment. The
Medicare payment amount takes into account the wage index
adjustment and the beneficiary deductible and coinsurance
amounts. NOTE: There is no CWF edit check to validate that
the revenue center Medicare payment amount equals the claim
level Medicare payment amount.

Under Home Health PPS, beneficiaries will be classified into
an appropriate case mix category known as the Home Health
Resource Group. A HIPPS code is then generated
corresponding to the case mix category (HHRG).

For the RAP, the PRICER will determine the payment amount
appropriate to the HIPPS code by computing 60% (for first
episode) or 50% (for subsequent episodes) of the case mix
episode payment. The payment is then wage index adjusted.

For the final claim, PRICER calculates 100% of the amount
due, because the final claim is processed as an adjustment
to the RAP, reversing the RAP payment in full. Although
final claim will show 100% payment amount, the provider will
actually receive the 40% or 50% payment.

Exceptions: For claims involving demos and BBA encounter
data, the amount reported in this field may not just
represent the actual provider payment.

For demo Ids '01','02','03','04' -- claims contain
amount paid to the provider, except that special
'differentials' paid outside the normal payment system
are not included.

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For demo Ids '05','15' -- encounter data 'claims'
contain amount Medicare would have paid under FFS,
instead of the actual payment to the MCO.

For demo Ids '06','07','08' -- claims contain actual
provider payment but represent a special negotiated
bundled payment for both Part A and Part B services.
To identify what the conventional provider Part A
payment would have been, check value code = 'Y4'.   The
related noninstitutional (physician/supplier) claims
contain what would have been paid had there been no
demo.

For BBA encounter data (non-demo) -- 'claims' contain
amount Medicare would have paid under FFS, instead of
the actual payment to the BBA plan.

9.2 DIGITS SIGNED

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| | | | POSITIONS | | |
NAME	TYPE	LENGTH	BEG	END	CONTENTS
					COMMON ALIAS: REIMBURSEMENT
					DB2 ALIAS: CLM_PMT_AMT
					SAS ALIAS: PMT_AMT
					STANDARD ALIAS: CLM_PMT_AMT
					TITLE ALIAS: REIMBURSEMENT

EDIT-RULES:
$$$$$$$$$CC

COMMENT:
Prior to Version H the size of this field was S9(7)V99. Als
the noninstitutional claim records carried this field as a l
item. Effective with Version H, this element is a claim lev
field across all claim types (and the line item field has be
renamed.)

SOURCE:

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LIMITATIONS:
Prior to 4/6/93, on inpatient, outpatient, and
physician/supplier claims containing a
CLM_DISP_CD of '02', the amount shown as the Medicare
reimbursement does not take into consideration
any CWF automatic adjustments (involving erroneous
deductibles in most cases). In as many as 30% of
the claims (30% IP, 15% OP, 5% PART B), the
reimbursement reported on the claims may be over
or under the actual Medicare payment amount.

60. NCH Primary Payer Claim   PACK   6   284 289   The amount of a payment made on behalf of a Medicare
    Paid Amount   beneficiary by a primary payer other than Medicare, that the
                                                        provider is applying to covered Medicare charges on an
                                                        institutional, carrier, or DMERC claim.

                                                        9.2 DIGITS SIGNED

                                                        DB2 ALIAS: PRMRY_PYR_PD_AMT
                                                        SAS ALIAS: PRPAYAMT
                                                        STANDARD ALIAS: NCH_PRMRY_PYR_CLM_PD_AMT
                                                        TITLE ALIAS: PRIMARY_PAYER_AMOUNT

                                                        EDIT-RULES:
                                                        $$$$$$$$$CC

                                                        COMMENT:
                                                        Prior to Version H this field was named:
                                                        BENE_PRMRY_PYR_CLM_PMT_AMT and the field size
                                                        was S9(7)V99.

                                                        SOURCE:
                                                        NCH

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                                          POSITIONS
              NAME   TYPE   LENGTH BEG   END   CONTENTS
    ---------------------------- ---- ------ --------- ---

    61. NCH Primary Payer Code   CHAR   1   290 290   The code, on an institutional claim, specifying a federal
                                                          non-Medicare program or other source that has primary

responsibility for the payment of the Medicare beneficiary's
health insurance bills.

DB2 ALIAS: NCH_PRMRY_PYR_CD
SAS ALIAS: PRPAY_CD
STANDARD ALIAS: NCH_PRMRY_PYR_CD
TITLE ALIAS: PRIMARY_PAYER_CD

DERIVATION:
DERIVED FROM:
    CLM_VAL_CD
    CLM_VAL_AMT

DERIVATION RULES

  SET NCH_PRMRY_PYR_CD TO 'A' WHERE THE
  CLM_VAL_CD = '12'

  SET NCH_PRMRY_PYR_CD TO 'B' WHERE THE
  CLM_VAL_CD = '13'

  SET NCH_PRMRY_PYR_CD TO 'C' WHERE THE
  CLM_VAL_CD = '16' and CLM_VAL_AMT is zeroes

  SET NCH_PRMRY_PYR_CD TO 'D' WHERE THE
  CLM_VAL_CD = '14'

  SET NCH_PRMRY_PYR_CD TO 'E' WHERE THE
  CLM_VAL_CD = '15'

  SET NCH_PRMRY_PYR_CD TO 'F' WHERE THE
  CLM_VAL_CD = '16' (CLM_VAL_AMT not
  equal to zeroes)

  SET NCH_PRMRY_PYR_CD TO 'G' WHERE THE
  CLM_VAL_CD = '43'

  SET NCH_PRMRY_PYR_CD TO 'H' WHERE THE
  CLM_VAL_CD = '41'

  SET NCH_PRMRY_PYR_CD TO 'I' WHERE THE
  CLM_VAL_CD = '42'

  SET NCH_PRMRY_PYR_CD TO 'L' (or prior to 4/97

                    set code to 'J') WHERE THE CLM_VAL_CD = '47'

                    CODES:
                      REFER TO: BENE_PRMRY_PYR_TB
                                IN THE CODES APPENDIX

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                                        POSITIONS
              NAME   TYPE LENGTH BEG END   CONTENTS
    ---------------------------   ---- ------ --------- ---

                                                           COMMENT:
                                                           Prior to Version H this field was named:
                                                           BENE_PRMRY_PYR_CD.

                                                           SOURCE:
                                                           NCH

    62. FI Requested Claim Cancel CHAR   1   291 291   The reason that an intermediary requested cancelling
        Reason Code   a previously submitted institutional claim.

                                                           DB2 ALIAS: RQST_CNCL_RSN_CD
                                                           SAS ALIAS: CANCELCD
                                                           STANDARD ALIAS: FI_RQST_CLM_CNCL_RSN_CD
                                                           TITLE ALIAS: CANCEL_CD

                                                           CODES:
                                                             REFER TO: FI_RQST_CLM_CNCL_RSN_TB
                                                                     IN THE CODES APPENDIX

                                                           COMMENT:
                                                           Prior to Version H this field was named:
                                                           INTRMDRY_RQST_CLM_CNCL_RSN_CD.

                                                           SOURCE:
                                                           CWF

    63. FI Claim Action Code   CHAR   1   292 292   The type of action requested by the intermediary
                                                           to be taken on an institutional claim.

                                                           DB2 ALIAS: FI_CLM_ACTN_CD
                                                           SAS ALIAS: ACTIONCD
                                                           STANDARD ALIAS: FI_CLM_ACTN_CD

                         TITLE ALIAS: ACTION_CD

                         CODES:
                           REFER TO: FI_CLM_ACTN_TB
                                     IN THE CODES APPENDIX

                         COMMENT:
                         Prior to Version H this field was named:
                         INTRMDRY_CLM_ACTN_CD.

                         SOURCE:
                         CWF

 64. FI Claim Process Date   NUM   8   293 300   The date the fiscal intermediary completes
                                                        processing and releases the institutional
                                                        claim to the CWF host.

                                                        8 DIGITS UNSIGNED

                                                        DB2 ALIAS: FI_CLM_PROC_DT
                                                        SAS ALIAS: APRVL_DT
                                                        STANDARD ALIAS: FI_CLM_PROC_DT
                                                        TITLE ALIAS: FI_PROCESS_DT
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                                         POSITIONS
                 NAME   TYPE LENGTH BEG END   CONTENTS
    ---------------------------   ---- ------ --------- --

                                                        EDIT-RULES:
                                                        YYYYMMDD

                                                        SOURCE:
                                                        CWF

 65. NCH Provider State Code   CHAR   2   301 302   Effective with Version H, the two position SSA state code
                                                        where provider facility is located.

                                                        NOTE: During the Version H conversion this field was
                                                        populated with data throughout history (back to service year
                                                        1991).

                                                        DB2 ALIAS: NCH_PRVDR_STATE_CD
                                                        SAS ALIAS: PRSTATE

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                              inpatientsnf.txt
                      STANDARD ALIAS: NCH_PRVDR_STATE_CD
                      TITLE ALIAS: PROVIDER_STATE_CD

                      DERIVATION:
                      DERIVED FROM:
                        NCH PRVDR_NUM

                      DERIVATION RULES:

                        SET NCH_PRVDR_STATE_CD TO
                            PRVDR_NUM POS1-2.
                        FOR PRVDR_NUM POS1-2 EQUAL '55
                          SET NCH_PRVDR_STATE_CD TO '05'.
                        FOR PRVDR_NUM POS1-2 EQUAL '67
                          SET NCH_PRVDR_STATE_CD TO '45'.
                        FOR PRVDR_NUM POS1-2 EQUAL '68
                          SET NCH_PRVDR_STATE_CD TO '10'.

                      CODES:
                        REFER TO: GEO_SSA_STATE_TB
                                    IN THE CODES APPENDIX

                      SOURCE:
                      NCH

  66. Organization NPI Number     CHAR    10   303  312  A placeholder field (effective with Version H) for storing
                                                         the NPI assigned to the institutional provider.

                      DB2 ALIAS: ORG_NPI_NUM
                      SAS ALIAS: ORGNPINM
                      STANDARD ALIAS: ORG_NPI_NUM
                      TITLE ALIAS: ORG_NPI

                      SOURCE:
                      CWF

 ****  Attending Physician ID     GROUP   24   313  336  Name and identification numbers associated
       Group                                             with the primary care physician.
```

```
                                     POSITIONS
                NAME             TYPE  LENGTH BEG  END                        CONTENTS
       ----------------------------  ----  ------ ---------  ------------------------------------------------------------
```

STANDARD ALIAS: ATNDG_PHYSN_ID_GRP

67. Claim Attending Physician   CHAR   6   313   318   On an institutional claim, the unique physician
    UPIN Number   identification number (UPIN) of the physician
                                                          who would normally be expected to certify and
                                                          recertify the medical necessity of the services
                                                          rendered and/or who has primary responsibility for
                                                          the beneficiary's medical care and treatment
                                                          (attending physician).

                                                          COMMON ALIAS: ATTENDING_PHYSICIAN_UPIN
                                                          DB2 ALIAS: ATNDG_UPIN
                                                          SAS ALIAS: AT_UPIN
                                                          STANDARD ALIAS: CLM_ATNDG_PHYSN_UPIN_NUM
                                                          TITLE ALIAS: ATTENDING_PHYSICIAN

                                                          COMMENT:
                                                          Prior to Version H this field was named:
                                                          CLM_PRMRY_CARE_PHYSN_IDENT_NUM and contained
                                                          10 positions (6-position UPIN and 4-position
                                                          physician surname).

                                                          SOURCE:
                                                          CWF

68. Claim Attending Physician   CHAR   10   319   328   A placeholder field (effective with Version H)
    NPI Number   for storing the NPI assigned to the attending
                                                          physician.

                                                          COMMON ALIAS: ATTENDING_PHYSICIAN_NPI
                                                          DB2 ALIAS: ATNDG_NPI
                                                          SAS ALIAS: AT_NPI
                                                          STANDARD ALIAS: CLM_ATNDG_PHYSN_NPI_NUM
                                                          TITLE ALIAS: ATNDG_NPI

                                                          SOURCE:
                                                          CWF

69. Claim Attending Physician   CHAR   6   329   334   Effective with Version H, the last name of the
    Surname   attending physician (used for internal editing
                                                          purpose in HCFA's CWFMQA system.)

                                                          NOTE: Beginning with NCH weekly process date

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                                inpatientsnf.txt
                                10/3/97 this field was populated with data.
                                Claims processed prior to 10/3/97 will contain
                                spaces in this field.

                                DB2 ALIAS: ATNDG_SRNM
                                SAS ALIAS: AT_SRNM
                                STANDARD ALIAS: CLM_ATNDG_PHYSN_SRNM_NAME
                                TITLE ALIAS: ANDG_PHYSN_SURNAME

                                SOURCE:
                                CWF
```

```
                                         POSITIONS
              NAME              TYPE  LENGTH BEG   END                            CONTENTS
     ----------------------------  ----  ------  ---------  ------------------------------------------------------------

  70. Claim Attending Physician   CHAR     1    335   335   Effective with Version H, the first name of the
      Given Name                                            attending physician (used for internal editing
                                                            purposes in HCFA's CWFMQA system).

                                                            NOTE:  Beginning with NCH weekly process date
                                                            10/3/97 this field was populated with data.
                                                            Claims processed prior to 10/3/97 will contain
                                                            spaces in this field.

                                                            DB2 ALIAS: ATNDG_GVN_NAME
                                                            SAS ALIAS: AT_GVNNM
                                                            STANDARD ALIAS: CLM_ATNDG_PHYSN_GVN_NAME
                                                            TITLE ALIAS: ATNDG_PHYSN_FIRSTNAME

                                                            SOURCE:
                                                            CWF

  71. Claim Attending Physician   CHAR     1    336   336   Effective with Version H, the middle initial
      Middle Initial Name                                   of the attending physician (used for internal
                                                            editing purposes in HCFA's CWFMQA system.)

                                                            NOTE:  Beginning with NCH weekly process date
                                                            10/3/97 this field was populated with data.
                                                            Claims processed prior to 10/3/97 will contain
                                                            spaces in this field.
```

```
                                    DB2 ALIAS: ATNDG_MI_NAME
                                    SAS ALIAS: AT_MDL
                                    STANDARD ALIAS: CLM_ATNDG_PHYSN_MDL_INITL_NAME
                                    TITLE ALIAS: ATNDG_PHYSN_MI

                                    SOURCE:
                                    CWF
```

	NAME	TYPE	LENGTH	BEG	END	CONTENTS
****	Operating Physician ID Group	GROUP	24	337	360	Name and identification numbers associated with the physician who performed the principal procedure.

STANDARD ALIAS: OPRTG_PHYSN_ID_GRP

	NAME	TYPE	LENGTH	BEG	END	CONTENTS
72.	Claim Operating Physician UPIN Number	CHAR	6	337	342	On an institutional claim, the unique physician identification number (UPIN) of the physician who performed the principal procedure. This element is used by the provider to identify the operating physician who performed the surgi-cal procedure.

```
                                    DB2 ALIAS: OPRTG_UPIN
                                    SAS ALIAS: OP_UPIN
                                    STANDARD ALIAS: CLM_OPRTG_PHYSN_UPIN_NUM
                                    TITLE ALIAS: OPRTG_UPIN
```

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                                          POSITIONS
              NAME              TYPE  LENGTH BEG  END                        CONTENTS
    ----------------------------  ----  ------ ---------  ------------------------------------------------------------
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```
                                    COMMENT:
                                    Prior to Version H this field was named:
                                    CLM_PRNCPAL_PRCDR_PHYSN_NUM and contained
                                    10 positions (6-position UPIN and 4-position
                                    physician surname.

                                    NOTE:  For HHA and Hospice formats beginning
                                    with NCH weekly process date 10/3/97 this field
                                    was populated with data.  HHA and Hospice claims
                                    processed prior to 10/3/97 will contain spaces.

                                    SOURCE:
```

CWF

73. Claim Operating Physician   CHAR   10   343   352   A placeholder field (effective with Version H)
    NPI Number   for storing the NPI assigned to the operating
                                                           physician.

                                                           DB2 ALIAS: OPRTG_NPI
                                                           SAS ALIAS: OP_NPI
                                                           STANDARD ALIAS: CLM_OPRTG_PHYSN_NPI_NUM
                                                           TITLE ALIAS: OPRTG_NPI

                                                           SOURCE:
                                                           CWF

74. Claim Operating Physician   CHAR   6   353   358   Effective with Version H, the last name of the
    Surname   operating physician (used for internal editing
                                                           purposes in HCFA's CWFMQA system.)

                                                           NOTE: Beginning with the NCH weekly process date
                                                           10/3/97 this field was populated with data.
                                                           Claims processed prior to 10/3/97 will contain
                                                           spaces in this field.

                                                           DB2 ALIAS: OPRTG_SRNM
                                                           SAS ALIAS: OP_SRNM
                                                           STANDARD ALIAS: CLM_OPRTG_PHYSN_SRNM_NAME
                                                           TITLE ALIAS: OPRTG_PHYSN_SURNAME

                                                           SOURCE:
                                                           CWF

75. Claim Operating Physician   CHAR   1   359   359   Effective with Version H, the first name
    Given Name   of the operating physician (used for internal
                                                           editing purposes in HCFA's CWFMQA system.)

                                                           NOTE: Beginning with NCH weekly process date
                                                           10/3/97 this field was populated with data.
                                                           Claims processed prior to 10/3/97 will contain
                                                           spaces in this field.

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                                               POSITIONS
                    NAME   TYPE   LENGTH BEG   END   CONTENTS

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                                                      DB2 ALIAS: OPRTG_GVN_NAME
                                                      SAS ALIAS: OP_GVN
                                                      STANDARD ALIAS: CLM_OPRTG_PHYSN_GVN_NAME
                                                      TITLE ALIAS: OPRTG_PHYSN_FIRSTNAME

                                                      SOURCE:
                                                      CWF

76. Claim Operating Physician   CHAR   1   360 360 Effective with Version H, the middle initial
    Middle Initial Name   of the operating physician (used for internal
                                                        editing purposes in HCFA's CWFMQA system.)

                                                      NOTE: Beginning with NCH weekly process date
                                                      10/3/97 this field was populated with data.
                                                      Claims processed prior to 10/3/97 will contain
                                                      spaces in this field.

                                                      DB2 ALIAS: OPRTG_MI_NAME
                                                      SAS ALIAS: OP_MDL
                                                      STANDARD ALIAS: CLM_OPRTG_PHYSN_MDL_INITL_NAME
                                                      TITLE ALIAS: OPRTG_PHYSN_MI

                                                      SOURCE:
                                                      CWF

**** Other Physician ID Group   GROUP 24   361 384 Name and identification numbers associated with the other
                                                        physician.

                                                      STANDARD ALIAS: OTHR_PHYSN_ID_GRP

77. Claim Other Physician UPIN   CHAR   6   361 366 On an institutional claim, the unique physician
    Number   identification number (UPIN) of the other
                                                        physician associated with the institutional
                                                        claim.

                                                      DB2 ALIAS: OTHR_UPIN
                                                      SAS ALIAS: OT_UPIN
                                                      STANDARD ALIAS: CLM_OTHR_PHYSN_UPIN_NUM
                                                      TITLE ALIAS: OTH_PHYSN_UPIN

                                                      COMMENT:
                                                      Prior to Version H this field was named:

CLM_OTHR_PHYSN_IDENT_NUM and contained
10 positions (6-position UPIN and 4-position
other physician surname).

NOTE: For HHA and Hospice formats beginning
with NCH weekly process date 10/3/97 this field
was populated with data. HHA and Hospice claims
processed prior to 10/3/97 will contain spaces.

SOURCE:
CWF

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                                    POSITIONS
            NAME                TYPE  LENGTH BEG   END                        CONTENTS
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78. Claim Other Physician NPI   CHAR   10   367 376   A placeholder field (effective with Version H
    Number   for storing the NPI assigned to the other
                                                           physician.

                                                           DB2 ALIAS: OTHR_NPI
                                                           SAS ALIAS: OT_NPI
                                                           STANDARD ALIAS: CLM_OTHR_PHYSN_NPI_NUM

                                                           SOURCE:
                                                           CWF

79. Claim Other Physician   CHAR   6   377 382   Effective with Version H, the last name of the
    Surname   other physician (used for internal editing
                                                           purposes in HCFA's CWFMQA system.)

                                                           NOTE: Beginning with the NCH weekly process date
                                                           10/3/97 this field was populated with data.
                                                           Claims processed prior to 10/3/97 will contain
                                                           spaces in this field.

                                                           DB2 ALIAS: OTHR_SRNM
                                                           SAS ALIAS: OT_SRNM
                                                           STANDARD ALIAS: CLM_OTHR_PHYSN_SRNM_NAME
                                                           TITLE ALIAS: OTH_PHYSN_SURNAME

                                                           SOURCE:

CWF

80. Claim Other Physician Given CHAR   1   383 383   Effective with Version H, the first name of the
    Name   other physician (used for internal editing
                                                         purposes in HCFA's CWFMQA system.)

                                                         NOTE: Beginning with NCH weekly process date
                                                         10/3/97 this field was populated with data.
                                                         Claims processed prior to 10/3/97 will contain
                                                         spaces in this field.

                                                         DB2 ALIAS: OTHR_GVN_NAME
                                                         SAS ALIAS: OT_GVN
                                                         STANDARD ALIAS: CLM_OTHR_PHYSN_GVN_NAME
                                                         TITLE ALIAS: OTH_PHYSN_FIRSTNAME

                                                         SOURCE:
                                                         CWF

81. Claim Other Physician   CHAR   1   384 384   Effective with Version H, the middle initial of
    Middle Initial Name   the other physician (used for internal editing
                                                         purposes in HCFA's CWFMQA system.)

                                                         NOTE: Beginning with NCH weekly process date
                                                         10/3/97 this field was populated with data.
                                                         Claims processed prior to 10/3/97 will contain
                                                         spaces in this field.

                                      POSITIONS
            NAME   TYPE LENGTH BEG   END   CONTENTS
    --------------------------- ---- ------ --------- --

                                                         DB2 ALIAS: OTHR_MI_NAME
                                                         SAS ALIAS: OT_MDL
                                                         STANDARD ALIAS: CLM_OTHR_PHYSN_MDL_INITL_NAME
                                                         TITLE ALIAS: OTH_PHYSN_MI

                                                         SOURCE:
                                                         CWF

82. Medicaid Provider   CHAR   13   385 397   A unique identification number assigned to each provider by
    Identification Number   the state Medicaid agency. This unique provider number is

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used to ensure proper payment of providers and to maintain
claims history on individual providers for surveillance and
utilization review.

DB2 ALIAS: MDCD_PRVDR_NUM
SAS ALIAS: MDCD_PRV
STANDARD ALIAS: MDCD_PRVDR_IDENT_NUM
TITLE ALIAS: MEDICAID_PROVIDER

COMMENT:
Prior to Version H the field size was X(12).

SOURCE:
CWF

83. Claim Medicaid Information   CHAR   4   398 401   Effective with Version G, code identifying Medicaid
    Code   information supplied by the contractor to Medicaid.

DB2 ALIAS: CLM_MDCD_INFO_CD
SAS ALIAS: MDCDINFO
STANDARD ALIAS: CLM_MDCD_INFO_CD
TITLE ALIAS: MEDICAID_INFO

SOURCE:
CWF

84. Claim MCO Paid Switch   CHAR   1   402 402   A switch indicating whether or not a Managed Care
                                                         Organization (MCO) has paid the provider for an
                                                         institutional claim.

COBOL ALIAS: MCO_PD_IND
DB2 ALIAS: CLM_MCO_PD_SW
SAS ALIAS: MCOPDSW
STANDARD ALIAS: CLM_MCO_PD_SW
TITLE ALIAS: MCO_PAID_SW

CODES:
1 = MCO has paid the provider for a claim
Blank or 0 = MCO has not paid the provider
             for a claim

COMMENT:
Prior to Version H this field was named:
CLM_GHO_PD_SW.

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                                      POSITIONS
              NAME              TYPE  LENGTH BEG  END                        CONTENTS
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```

                                                       SOURCE:
                                                       CWF

85. Claim Treatment   CHAR   18   403 420 The number assigned by the medical reviewer and
    Authorization Number   reported by the provider to identify the
                                                        medical review (treatment authorization)
                                                        action taken after review of the beneficiary's
                                                        case. It designates that treatment covered
                                                        by the bill has been authorized by the payer.
                                                        This number is used by the intermediary and
                                                        the Peer Review Organization.

                                                        NOTE: Under HH PPS this field will be used to
                                                        link claims to the OASIS assessment used as the
                                                        basis of payment. This eighteen character string
                                                        consists of the start of care date, the OASIS
                                                        assessment date and the two digit reason for
                                                        assessment code.

                                                        COMMON ALIAS: TAN
                                                        DB2 ALIAS: TRTMT_AUTHRZTN_NUM
                                                        SAS ALIAS: AUTHRZTN
                                                        STANDARD ALIAS: CLM_TRTMT_AUTHRZTN_NUM
                                                        TITLE ALIAS: TREATMENT_AUTHORIZATION

                                                        SOURCE:
                                                        CWF

86. Patient Control Number   CHAR   20   421 440 The unique alphanumeric identifier assigned by the
                                                        provider to the institutional claim to facilitate
                                                        retrieval of individual case records and posting
                                                        of payments.

                                                        DB2 ALIAS: PTNT_CNTL_NUM
                                                        SAS ALIAS: PTNTCNTL
                                                        STANDARD ALIAS: PTNT_CNTL_NUM
                                                        TITLE ALIAS: PATIENT_CONTROL_NUM

SOURCE:
CWF

87. Claim Medical Record Number CHAR   17   441 457   The number assigned by the provider to the
                                                         beneficiary's medical record to assist in record
                                                         retrieval.

                                                         DB2 ALIAS: CLM_MDCL_REC_NUM
                                                         SAS ALIAS: MDCL_REC
                                                         STANDARD ALIAS: CLM_MDCL_REC_NUM
                                                         TITLE ALIAS: MEDICAL_RECORD_NUM

                                                         SOURCE:
                                                         CWF

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                        POSITIONS
                 NAME   TYPE LENGTH BEG END   CONTENTS
        ---------------------------- ---- ------ --------- --

88. Claim PRO Control Number   CHAR   12   458 469   Effective with Version G, the unique identifier
                                                       assigned by the Peer Review Organization (PRO)
                                                       for control purposes.

                                                       DB2 ALIAS: CLM_PRO_CNTL_NUM
                                                       SAS ALIAS: PRO_CNTL
                                                       STANDARD ALIAS: CLM_PRO_CNTL_NUM
                                                       TITLE ALIAS: PRO_CONTROL_NUM

                                                       SOURCE:
                                                       CWF

89. Claim PRO Process Date   NUM   8   470 477   Effective with Version H, the date the claim was
                                                       used in the PRO review process.

                                                       NOTE: Beginning with NCH weekly process date
                                                       10/3/97 this field was populated with data.
                                                       Claims processed prior to 10/3/97 will contain
                                                       zeroes in this field.

                                                       8 DIGITS UNSIGNED

DB2 ALIAS: CLM_PRO_PROC_DT
SAS ALIAS: PRO_DT
STANDARD ALIAS: CLM_PRO_PROC_DT
TITLE ALIAS: PRO_PROC_DT

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

```
90. Patient Discharge Status     CHAR    2   478  479   The code used to identify the status of the
    Code                                                patient as of the CLM_THRU_DT.
```

COMMON ALIAS: DISCHARGE_DESTINATION/PATIENT_STATUS
DB2 ALIAS: PTNT_DSCHRG_STUS
SAS ALIAS: STUS_CD
STANDARD ALIAS: PTNT_DSCHRG_STUS_CD
SYSTEM ALIAS: LTCLMST
TITLE ALIAS: PTNT_DSCHRG_STUS_CD

CODES:
  REFER TO: PTNT_DSCHRG_STUS_TB
            IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
CLM_STUS_CD.

SOURCE:
CWF

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

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                                          POSITIONS
            NAME               TYPE  LENGTH BEG  END                        CONTENTS
    ---------------------------  ----  ------ --------  ------------------------------------------------------------

91. Claim Diagnosis E Code       CHAR     5   480  484   Effective with Version H, the ICD-9-CM code
                                                         used to identify the external cause of injury,
                                                         poisoning, or other adverse affect.  Redundantly
                                                         this field is also stored as the last occurrence
                                                         of the diagnosis trailer.
```

inpatientsnf.txt
NOTE: During the Version H conversion, the data
in the last occurrence of the diagnosis trailer
was used to populate history.

DB2 ALIAS: CLM_DGNS_E_CD
SAS ALIAS: DGNS_E
STANDARD ALIAS: CLM_DGNS_E_CD
TITLE ALIAS: DGNS_E_CD

SOURCE:
CWF

92. FILLER	CHAR	1	485	485	

93. Claim PPS Indicator Code   CHAR   1   486   486   Effective with Version H, the code indicating
whether or not the (1) claim is PPS and/or (2)
the beneficiary is a deemed insured Medicare
Qualified Government Employee (MQGE).

NOTE: Beginning with NCH weekly process date
10/3/97 through 5/29/98, this field was pop-
ulated with only the PPS indicator. Beginning with
NCH weekly process date 6/5/98, this field was
additionally populated with the deemed MQGE
indicator. Claims processed prior to 10/3/97
will contain spaces.

COBOL ALIAS: PPS_IND
DB2 ALIAS: CLM_PPS_IND_CD
SAS ALIAS: PPS_IND
STANDARD ALIAS: CLM_PPS_IND_CD
TITLE ALIAS: PPS_IND

CODES:
   REFER TO: CLM_PPS_IND_TB
                 IN THE CODES APPENDIX

SOURCE:
CWF

94. Claim Total Charge Amount   PACK   6   487   492   Effective with Version G, the total charges for
all services included on the institutional claim.
This field is redundant with revenue center
code 0001/total charges.

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9.2 DIGITS SIGNED

```
                                        POSITIONS
            NAME                 TYPE  LENGTH BEG  END                          CONTENTS
    ----------------------------  ----  ------ ---------   ------------------------------------------------------------
```

DB2 ALIAS: CLM_TOT_CHRG_AMT
SAS ALIAS: TOT_CHRG
STANDARD ALIAS: CLM_TOT_CHRG_AMT
TITLE ALIAS: CLAIM_TOTAL_CHARGES

COMMENT:
Prior to Version H the size of this field was
S9(7)V99.

SOURCE:
CWF

95. FILLER   CHAR   50   493 542

96. Inpatient/SNF NCH Edit Code NUM   2   543 544   The count of the number of edit codes
    Count   annotated to the inpatient/SNF claim
                                                          during the HCFA's CWFMQA process.
                                                          The purpose of this count is to indicate
                                                          how many claim edit trailers are present.

                                                          2 DIGITS UNSIGNED

                                                          DB2 ALIAS: IP_NCH_EDIT_CD_CNT
                                                          SAS ALIAS: IPEDCNT
                                                          STANDARD ALIAS: IP_NCH_EDIT_CD_CNT

                                                          COMMENT:
                                                          Prior to Version H this field was named:
                                                          CLM_EDIT_CD_CNT.

                                                          SOURCE:
                                                          NCH

97. Inpatient/SNF NCH Patch   NUM   2   545 546   Effective with Version H, the count of the
    Code Count   number of HCFA patch codes annotated to the

                                    Page 55

```
                        inpatientsnf.txt
                 inpatient/SNF claim during the Nearline
                 maintenance process.   The purpose of this
                 count is to indicate how many NCH patch
                 trailers are present.

                 NOTE1:  During the Version H conversion this
                 field was populated with data throughout
                 history (back to service year 1991).

                 NOTE2:  Effective with Version 'I' the number
                 of possible occurrences was reduced to 30.
                 Prior to Version 'I' the number of possible
                 occurrences was 99).

                 2 DIGITS UNSIGNED

                 DB2 ALIAS: IP_PATCH_CD_CNT
                 SAS ALIAS: IPPATCNT
                 STANDARD ALIAS: IP_NCH_PATCH_CD_I_CNT
```

```
                                    POSITIONS
           NAME              TYPE  LENGTH BEG  END                        CONTENTS
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```
```
                                                 SOURCE:
                                                 NCH

98. Inpatient/SNF MCO Period   NUM     1    547  547  Effective with Version H, the count of the number of Managed
    Count                                              Care Organization (MCO) periods reported on an inpatient/SNF
                                                       claim.  The purpose of this count is to indicate how many
                                                       MCO period trailers are present.

                                                       NOTE:  Beginning with NCH weekly process date 10/3/97 this
                                                       field was populated with data.  Claims processed prior to
                                                       10/3/97 will contain zeroes in this field.

                                                       1 DIGIT UNSIGNED

                                                       DB2 ALIAS: IP_MCO_PRD_CNT
                                                       SAS ALIAS: IPMCOCNT
                                                       STANDARD ALIAS: IP_MCO_PRD_CNT
```

```
                    EDIT-RULES:
                    RANGE: 0 TO 2

                    SOURCE:
                    NCH

 99. Inpatient/SNF Claim Health   NUM    1   548  548   A placeholder field (effective with Version H)
     PlanID Count                                       for storing the count of the number of Health
                                                        PlanIDs reported on the inpatient/SNF claim.
                                                        The purpose of this count is to indicate how many
                                                        Health PlanID trailers are present.  NOTE: Prior
                                                        to Version 'I' this field was named:
                                                        IP_CLM_PAYERID_CNT.

                                                        1 DIGIT UNSIGNED

                                                        DB2 ALIAS: IP_CLM_PLANID_CNT
                                                        SAS ALIAS: IPPLANID
                                                        STANDARD ALIAS: IP_CLM_HLTH_PLANID_CNT

                                                        EDIT-RULES:
                                                        RANGE: 0 TO 3

                                                        COMMENT:
                                                        Prior to Version I this field was named:
                                                        IP_CLM_PAYERID_CNT.

                                                        SOURCE:
                                                        NCH

100. BEF Inpatient/SNF Claim      NUM    1   549  549   This field is blank on the beneficiary encrypted file.
     Demonstration ID Count
                                                        1 DIGIT UNSIGNED

                                                        DB2 ALIAS: BEF_IP_CLM_DEMO_ID
                                                        SAS ALIAS: IPDEMCNT
                                                        STANDARD ALIAS: IP_CLM_DEMO_ID_CNT
```

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                                         POSITIONS
            NAME                 TYPE  LENGTH BEG  END                        CONTENTS
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101. Inpatient/SNF Claim          NUM    2   550  551   The count of the number of diagnosis codes (both principal
```

Diagnosis Code Count

and other) reported on an inpatient/SNF claim. The purpose
of this count is to indicate how many claim diagnosis
trailers are present.

2 DIGITS UNSIGNED

DB2 ALIAS: IP_CLM_DGNS_CD_CNT
SAS ALIAS: IPDGNCNT
STANDARD ALIAS: IP_CLM_DGNS_CD_CNT

EDIT-RULES:
RANGE: 0 TO 10

COMMENT:
Prior to Version H this field was named:
CLM_OTHR_DGNS_CD_CNT and the principal was
not included in the count.

SOURCE:
CWF

102. Inpatient/SNF Claim   NUM   2   552 553   The count of the number of procedure codes (both principal
     Procedure Code Count   and other) reported on an inpatient/SNF claim. The purpose
                                                          of this count is to indicate how many claim procedure
                                                          trailers are present.

                                                          2 DIGITS UNSIGNED

                                                          DB2 ALIAS: IP_PRCDR_CD_CNT
                                                          SAS ALIAS: IPPRCNT
                                                          STANDARD ALIAS: IP_CLM_PRCDR_CD_CNT

                                                          EDIT-RULES:
                                                          RANGE: 0 TO 6

                                                          COMMENT:
                                                          Prior to Version H this field was named:
                                                          CLM_PRCDR_CD_CNT.

                                                          SOURCE:
                                                          CWF

103. Inpatient/SNF Claim Related NUM   2   554 555   The count of the number of condition codes reported on an
     Condition Code Count   inpatient/SNF claim. The purpose of this count is to

                         indicate how many condition code trailers are present.

                         2 DIGITS UNSIGNED

                         DB2 ALIAS: IP_RLT_COND_CD_CNT
                         SAS ALIAS: IPCONCNT
                         STANDARD ALIAS: IP_CLM_RLT_COND_CD_CNT

                         EDIT-RULES:
                         RANGE: 0 TO 30
1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                    POSITIONS
            NAME   TYPE LENGTH BEG END   CONTENTS
---------------------------- ---- ------ --------- --

                                                      COMMENT:
                                                      Prior to Version H this field was named:
                                                      CLM_RLT_COND_CD_CNT.

                                                      SOURCE:
                                                      CWF

  104. Inpatient/SNF Claim Related NUM   2   556 557 The count of the number of occurrence codes reported on an
       Occurrence Code Count   inpatient/SNF claim. The purpose of this count is to
                                                         indicate how many occurrence code trailers are present.

                                                      2 DIGITS UNSIGNED

                                                      DB2 ALIAS: IP_OCRNC_CD_CNT
                                                      SAS ALIAS: IPOCRCNT
                                                      STANDARD ALIAS: IP_CLM_RLT_OCRNC_CD_CNT

                                                      EDIT-RULES:
                                                      RANGE: 0 TO 30

                                                      COMMENT:
                                                      Prior to Version H this field was named:
                                                      CLM_RLT_OCRNC_CD_CNT.

                                                      SOURCE:
                                                      CWF

  105. Inpatient/SNF Claim   NUM   2   558 559 The count of the number of occurrence span codes

```
                                           reported on an inpatient/SNF claim.  The purpose
    Occurrence Span Code Count             of the count is to indicate how many span code
                                           trailers are present.

                                           2 DIGITS UNSIGNED

                                           DB2 ALIAS: IP_OCRNC_SPAN_CNT
                                           SAS ALIAS: IPSPNCNT
                                           STANDARD ALIAS: IP_CLM_OCRNC_SPAN_CD_CNT

                                           COMMENT:
                                           Prior to Version H this field was named:
                                           CLM_OCRNC_SPAN_CD_CNT.

                                           SOURCE:
                                           CWF

106. Inpatient/SNF Claim Value   NUM     2   560   561   The count of the number of value codes reported on
     Code Count                             an inpatient/SNF claim.  The purpose of the count
                                           is to indicate how many value code trailers are
                                           present.

                                           2 DIGITS UNSIGNED

                                           DB2 ALIAS: IP_VAL_CD_CNT
                                           SAS ALIAS: IPVALCNT
                                           STANDARD ALIAS: IP_CLM_VAL_CD_CNT
1                 FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                  POSITIONS
           NAME              TYPE  LENGTH BEG  END                          CONTENTS
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                                           EDIT-RULES:
                                           RANGE: 0 TO 36

                                           COMMENT:
                                           Prior to Version H this field was named:
                                           CLM_VAL_CD_CNT.

                                           SOURCE:
                                           CWF

107. Inpatient/SNF Revenue       NUM     2   562   563   The count of the number of revenue codes
```

Center Code Count

reported on an inpatient/SNF claim. The
purpose of the count is to indicate how
many revenue center trailers are present.

2 DIGITS UNSIGNED

DB2 ALIAS: IP_REV_CNTR_CD_CNT
SAS ALIAS: IPREVCNT
STANDARD ALIAS: IP_REV_CNTR_CD_I_CNT

EDIT-RULES:
RANGE: 0 TO 45

COMMENT:
Prior to Version H this field was named:
CLM_REV_CNTR_CD_CNT.

NOTE: During the Version 'I' conversion the
        number of occurrences changed to 45 (per
        segment - 450 total for claim). For
        claims prior to Version 'I' the number of
        occurrences was 58, but in the conversion
        we made all claims back to service year
        1991 contain only 45 revenue center lines.
        It is possible that claims prior to 1991
        will have 2 segments if they contained
        more than 45 revenue lines.

SOURCE:
CWF

#						
108.	FILLER	CHAR	4	564	567	

**** FI Inpatient SNF Claim   GROUP 288 568 855 Data pertaining only to fiscal intermediary inpatient
     Specific Group   or SNF claims

                                                      STANDARD ALIAS: FI_IP_SNF_CLM_SPECF_GRP

109. Claim Admission Date   NUM   8 568 575 On an institutional claim, the date the beneficiary
                                                      was admitted to the hospital, skilled nursing
                                                      facility, or christian science sanitorium.

                                                      8 DIGITS UNSIGNED

```
                                       POSITIONS
            NAME              TYPE  LENGTH BEG  END                         CONTENTS
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                                                      DB2 ALIAS: CLM_ADMSN_DT
                                                      SAS ALIAS: ADMSN_DT
                                                      STANDARD ALIAS: CLM_ADMSN_DT
                                                      TITLE ALIAS: ADMISSION_DT

                                                      EDIT-RULES:
                                                      YYYYMMDD

                                                      SOURCE:
                                                      CWF

110. Claim Inpatient Admission  CHAR    1   576  576  The code indicating the type and priority of an
     Type Code                                        inpatient admission associated with the service
                                                      on an intermediary submitted claim.

                                                      DB2 ALIAS: IP_ADMSN_TYPE_CD
                                                      SAS ALIAS: TYPE_ADM
                                                      STANDARD ALIAS: CLM_IP_ADMSN_TYPE_CD
                                                      TITLE ALIAS: IP_ADMISSION_TYPE

                                                      CODES:
                                                        REFER TO: CLM_IP_ADMSN_TYPE_TB
                                                                      IN THE CODES APPENDIX

                                                      SOURCE:
                                                      CWF

111. Claim Source Inpatient     CHAR    1   577  577  The code indicating the means by which the
     Admission Code                                   beneficiary was admitted to the inpatient health
                                                      care facility or SNF if the type of admission is
                                                      (1) emergency, (2) urgent, or (3) elective.

                                                      DB2 ALIAS: SRC_IP_ADMSN_CD
                                                      SAS ALIAS: SRC_ADMS
                                                      STANDARD ALIAS: CLM_SRC_IP_ADMSN_CD
                                                      TITLE ALIAS: IP_ADMISSION_SOURCE

                                                      CODES:
                                                        REFER TO: CLM_SRC_IP_ADMSN_TB
```

                        IN THE CODES APPENDIX

                        SOURCE:
                        CWF

112. Claim Admitting Diagnosis   CHAR   5   578 582   An ICD-9-CM code on the institutional inpatient/
     Code   SNF claim indicating the beneficiary's
                                                         initial diagnosis at admission.

                                                         DB2 ALIAS: CLM_ADMTG_DGNS_CD
                                                         SAS ALIAS: AD_DGNS
                                                         STANDARD ALIAS: CLM_ADMTG_DGNS_CD
                                                         TITLE ALIAS: ADMITTING_DIAGNOSIS

                                                         SOURCE:
                                                         CWF
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                                     POSITIONS
               NAME   TYPE LENGTH BEG END   CONTENTS
     ---------------------------   ---- ------ ---------   ---

113. FILLER   CHAR   1   583 583

114. NCH Patient Status   CHAR   1   584 584   Effective with Version H, the code on an
     Indicator Code   inpatient/SNF and Hospice claim, indicating
                                                          whether the beneficiary was discharged, died
                                                          or still a patient (used for internal CWFMQA
                                                          editing purposes.)

                                                          NOTE: During the Version H conversion this
                                                          field was populated throughout history (back to
                                                          service year 1991).

                                                          DB2 ALIAS: NCH_PTNT_STUS_IND
                                                          SAS ALIAS: PTNTSTUS
                                                          STANDARD ALIAS: NCH_PTNT_STUS_IND_CD
                                                          TITLE ALIAS: NCH_PATIENT_STUS

                                                          DERIVATION:
                                                          DERIVED FROM:
                                                            NCH PTNT_DSCHRG_STUS_CD

                                                          DERIVATION RULES:

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```
                          SET NCH_PTNT_STUS_IND_CD TO 'A' WHERE THE
                          PTNT_DSCHRG_STUS_CD NOT EQUAL TO '20'- '30'
                          OR '40' - '42'.

                          SET NCH_PTNT_STUS_IND_CD TO 'B' WHERE THE
                          PTNT_DSCHRG_STUS_CD EQUAL TO '20'- '29'
                          OR '40' - '42'.

                          SET NCH_PTNT_STUS_IND_CD TO 'C' WHERE THE
                          PTNT_DSCHRG_STUS_CD EQUAL TO '30'

                          CODES:
                          A = Discharged
                          B = Died
                          C = Still patient

                          SOURCE:
                          NCH QA Process
```

115. NCH Inpatient Pro Approval   CHAR   1   585   585   The Peer Review Organization (PRO) determination on the type
     Type Code   of approval or denial of an inpatient claim.

```
                          DB2 ALIAS: IP_PRO_APRVL_CD
                          SAS ALIAS: APRVL_CD
                          STANDARD ALIAS: NCH_IP_PRO_APRVL_TYPE_CD
                          TITLE ALIAS: PRO_IP_APPROVAL_CODE

                          DERIVATION:
                          Set based upon presence of condition code
                          equal TO C1, C3, C4, C5, C6 OR C7.
```

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                                     POSITIONS
              NAME              TYPE  LENGTH BEG  END                          CONTENTS
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```
                          CODES:
                            REFER TO: NCH_IP_PRO_APRVL_TYPE_TB
                                      IN THE CODES APPENDIX

                          COMMENT:
                          Prior to Version H this field was named:
```

CLM_IP_PRO_APRVL_TYPE_CD.

SOURCE:
NCH

116. NCH Inpatient PRO Approval   NUM   8   586 593   On an institutional claim, the start date of
     Service From Date   service that has been approved by the Peer
                                                           Review Organization (PRO).

                                                           8 DIGITS UNSIGNED

                                                           DB2 ALIAS: IP_PRO_FROM_DT
                                                           SAS ALIAS: PRO_FROM
                                                           STANDARD ALIAS: NCH_IP_PRO_SRVC_FROM_DT
                                                           TITLE ALIAS: PRO_FROM_DT

                                                           EDIT-RULES:
                                                           YYYYMMDD

                                                           DERIVATION:
                                                           DERIVED FROM:
                                                              CLM_OCRNC_SPAN_CD
                                                              CLM_OCRNC_SPAN_FROM_DT

                                                           DERIVATION RULES:
                                                           Based on the presence of occurrence span code
                                                           equal to 'MO' move the corresponding occurrence
                                                           span from date to the NCH_IP_PRO_SRVC_FROM_DT.

                                                           COMMENT:
                                                           Prior to Version H this field was named:
                                                           CLM_PRO_APRVL_SRVC_FROM_DT.

                                                           SOURCE:
                                                           NCH

117. NCH Inpatient PRO Approval   NUM   8   594 601   On an institutional claim, the last day of
     Service Thru Date   service that has been approved by the Peer
                                                           Review Organization (PRO).

                                                           8 DIGITS UNSIGNED

                                                           DB2 ALIAS: IP_PRO_THRU_DT
                                                           SAS ALIAS: PRO_THRU

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                          STANDARD ALIAS: NCH_IP_PRO_SRVC_THRU_DT
                          TITLE ALIAS: PRO_THRU

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             NAME   TYPE LENGTH BEG END   CONTENTS
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                                                       EDIT-RULES:
                                                       YYYYMMDD

                                                       DERIVATION:
                                                       DERIVED FROM:
                                                         CLM_OCRNC_SPAN_CD
                                                         CLM_OCRNC_SPAN_THRU_DT

                                                       DERIVATION RULES:
                                                       Based on the presence of occurrence span code
                                                       equal to 'MO' move the corresponding occurrence
                                                       span thru date to the NCH_IP_PRO_SRVC_THRU_DT.

                                                       COMMENT:
                                                       Prior to Version H this field was named:
                                                       CLM_PRO_APRVL_SRVC_THRU_DT.

                                                       SOURCE:
                                                       NCH

  118. NCH Inpatient PRO Approval   NUM   1   602 602 On an institutional claim, the number of days
       Grace Day Count   determined by a Peer Review Organization (PRO)
                                                          to be necessary to arrange post-discharge care.

                                                       1 DIGIT UNSIGNED

                                                       DB2 ALIAS: IP_PRO_GRC_CNT
                                                       SAS ALIAS: GRC_DAY
                                                       STANDARD ALIAS: NCH_IP_PRO_GRC_DAY_CNT
                                                       TITLE ALIAS: GRACE_DAYS

                                                       DERIVATION:
                                                       DERIVED FROM:
                                                         CLM_VAL_CD
                                                        CLM_VAL_AMT

DERIVATION RULES:
Based on the presence of value code equal to '46'
move the corresponding value amount to the
NCH_IP_PRO_GRC_DAY_CNT.

COMMENT:
Prior to Version H this field was named:
CLM_PRO_APRVL_GRC_DAY_CNT.

SOURCE:
NCH

119. Claim Pass Thru Per Diem   PACK   6   603 608   The amount of the established reimbursable costs
     Amount   for the current year divided by the estimated
                                                               Medicare days for the current year (all PPS
                                                               claims), as calculated by the FI and reim-
                                                               bursement staff. Items reimbursed as a pass
                                                               through include capital-related costs; direct

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                                            POSITIONS
                 NAME   TYPE LENGTH BEG   END   CONTENTS
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                                                               medical education costs; kidney acquisition
                                                               costs for hospitals approved as RTCs; and
                                                               bad debts (per Provider Reimbursement Manual,
                                                               Part 1, Section 2405.2). **Note: Pass throughs
                                                               are not included in the Claim Payment Amount.

                                                               9.2 DIGITS SIGNED

                                                               DB2 ALIAS: PASS_THRU_PER_DIEM
                                                               SAS ALIAS: PER_DIEM
                                                               STANDARD ALIAS: CLM_PASS_THRU_PER_DIEM_AMT
                                                               TITLE ALIAS: PER_DIEM

                                                               COMMENT:
                                                               Prior to Version H the field size was:
                                                               S9(5)V99.

                                                               SOURCE:
                                                               CWF

```
120. NCH Beneficiary Inpatient    PACK     6   609  614   The amount of the deductible the beneficiary paid
     Deductible Amount                                    for inpatient services, as originally submitted on
                                                          the institutional claim.

                                                          9.2 DIGITS SIGNED

                                                          DB2 ALIAS: BENE_IP_DDCTBL_AMT
                                                          SAS ALIAS: DED_AMT
                                                          STANDARD ALIAS: NCH_BENE_IP_DDCTBL_AMT
                                                          TITLE ALIAS: BENE_DED_AMT

                                                          DERIVATION:
                                                          DERIVED FROM:
                                                              CLM_VAL_CD
                                                              CLM_VAL_AMT

                                                          DERIVATION RULES:
                                                          Based on the presence of value code equal to
                                                          A1, B1, or C1 move the corresponding value
                                                          amount to the NCH_BENE_IP_DDCTBL_AMT.

                                                          COMMENT:
                                                          Prior to Version H this field was named:
                                                          BENE_IP_DDCTBL_AMT and the field size was
                                                          S9(5)V99).

                                                          SOURCE:
                                                          NCH

121. NCH Beneficiary Part A        PACK     6   615  620   The amount of money for which the intermediary has
     Coinsurance Liability                                determined that the beneficiary is liable for
     Amount                                               Part A coinsurance on the institutional claim.

                                                          9.2 DIGITS SIGNED
```

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                        POSITIONS
          NAME                    TYPE   LENGTH BEG   END                          CONTENTS
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                                                          DB2 ALIAS: PTA_COINSRNC_AMT
                                                          SAS ALIAS: COIN_AMT
                                                          STANDARD ALIAS: NCH_BENE_PTA_COINSRNC_AMT
```

inpatientsnf.txt
TITLE ALIAS: BENE_PTA_COINSURANCE

DERIVATION:
DERIVED FROM:
  CLM_VAL_CD
  CLM_VAL_AMT

DERIVATION RULES:
Based on the presence of value code equal to
8, 9, 10 or 11 move the corresponding value
amount to the NCH_BENE_IP_PTA_COINSRC_AMT.

COMMENT:
Prior to Version H this field was named:
BENE_PTA_COINSRNC_LBLTY_AMT and the field size
was S9(5)V99.

SOURCE:
NCH

122. NCH Beneficiary Blood   PACK   6   621 626   The amount of money for which the intermediary
     Deductible Liability Amount   determined the beneficiary is liable for the blood
                                                               deductible.

                                                               9.2 DIGITS SIGNED

                                                               DB2 ALIAS: BLOOD_DDCTBL_AMT
                                                               SAS ALIAS: BLDDEDAM
                                                               STANDARD ALIAS: NCH_BENE_BLOOD_DDCTBL_AMT
                                                               TITLE ALIAS: BLOOD_DEDUCTIBLE

                                                               DERIVATION:
                                                               DERIVED FROM:
                                                                 CLM_VAL_CD
                                                                 CLM_VAL_AMT

                                                               DERIVATION RULES:
                                                               Based on the presence of value code equal to
                                                               '06' move the corresponding value amount to
                                                               NCH_BENE_BLOOD_DDCTBL_AMT.

                                                               COMMENT:
                                                               Prior to Version H, this field was named:
                                                               BENE_BLOOD_DDCTBL_LBLTY_AMT and the field

inpatientsnf.txt
size was S9(5)V99. Also, for OP claims, this
field was stored in a blood trailer. Version
H eliminated the OP blood trailer.

SOURCE:
NCH QA PROCESS

```
                                       POSITIONS
             NAME              TYPE  LENGTH BEG  END                         CONTENTS
   ----------------------------  ----  ------ ---------  ------------------------------------------------------------
```

123. NCH Blood Total Charge   PACK   6   627 632   Effective with Version H, the total charge for
     Amount   blood usage (for internal CWFMQA editing
                                                         purposes).

                                                         NOTE: During the Version H conversion this field
                                                         was populated with data throughout history (back
                                                         to service year 1991).

                                                         9.2 DIGITS SIGNED

                                                         DB2 ALIAS: BLOOD_TOT_CHRG_AMT
                                                         SAS ALIAS: BLDTCHRG
                                                         STANDARD ALIAS: NCH_BLOOD_TOT_CHRG_AMT
                                                         TITLE ALIAS: BLOOD_CHARGES

                                                         DERIVATION:
                                                         DERIVED FROM:
                                                             REV_CNTR_CD
                                                             REV_CNTR_TOT_CHRG_AMT

                                                         DERIVATION RULES:
                                                         Based on the presence of revenue center codes
                                                         0380 thru 0389 move the related total charge
                                                         amount to the NCH_BLOOD_TOT_CHRG_AMT.

                                                         SOURCE:
                                                         NCH QA Process

124. NCH Blood Non-Covered   PACK   6   633 638   Effective with Version H, the total noncovered
     Charge Amount   charges for blood usage (for internal CWFMQA

inpatientsnf.txt
editing purposes).

NOTE: During the Version H conversion this field
was populated with data throughout history (back
to service year 1991).

9.2 DIGITS SIGNED

DB2 ALIAS: BLOOD_NCVR_AMT
SAS ALIAS: BLDNCHRG
STANDARD ALIAS: NCH_BLOOD_NCOV_CHRG_AMT
TITLE ALIAS: BLOOD_NCV_CHARGES

DERIVATION:
DERIVED FROM:
  REV_CNTR_CD
  REV_CNTR_NCOV_CHRG_AMT

DERIVATION RULES:
Based on the presence of revenue center codes equal
to 0380 thru 0389 move the related noncovered
charges to NCH_BLOOD_NCOV_CHRG_AMT.

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

| | | | POSITIONS | | |
NAME	TYPE	LENGTH	BEG	END	CONTENTS

SOURCE:
NCH QA Process

125. NCH Professional Component   PACK   6   639 644   Effective with Version H, for inpatient and out-
     Charge Amount   patient claims, the amount of physician and other
                                                           professional charges covered under Medicare Part B
                                                           (used for internal CWFMQA editing purposes and other
                                                           internal processes (e.g. if computing interim payment
                                                           these charges are deducted)).

                                                           NOTE: During the Version H conversion this field
                                                           was populated with data throughout history (back to
                                                           service year 1991).

                                                           9.2 DIGITS SIGNED

DB2 ALIAS: PROFNL_CMPNT_AMT
SAS ALIAS: PCCHGAMT
STANDARD ALIAS: NCH_PROFNL_CMPNT_CHRG_AMT
TITLE ALIAS: PROFNL_CMPNT_CHARGES

DERIVATION:

1. IF INPATIENT - DERIVED FROM:
   CLM_VAL_CD
   Clm_VAL_AMT

DERIVATION RULES:
Based on the presence of value code 04 or 05
move the related value amount to the
NCH_PROFNL_CMPNT_CHRG_AMT.

2. IF OUTPATIENT - DERIVED FROM:
   REV_CNTR_CD
   REV_CNTR_TOT_CHRG_AMT

DERIVATION RULES (Effective 10/98):
Based on the presence of revenue center codes
096X, 097X & 098X move the related total charge
amount to NCH_PROFNL_CMPNT_CHRG_AMT.

NOTE1: During the Version H conversion, this
field was populated with data throughout history
BUT the derivation rule applied to the outpatient
claim was incomplete (i.e., revenue codes 0972,
0973, 0974 and 0979 were omitted from the calcu-
lation).

SOURCE:
NCH QA Process

NAME	TYPE	LENGTH	BEG	END	CONTENTS
126. NCH Inpatient Noncovered Charge Amount	PACK	6	645	650	Effective with Version H, the noncovered charges for all accommodations and services, reported on an inpatient claim (used for internal CWFMQA editing purposes).

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

POSITIONS
NAME   TYPE LENGTH BEG END   CONTENTS

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```

NOTE: During the Version H conversion this field
was populated with data throughout history (back
to service year 1991).

9.2 DIGITS SIGNED

DB2 ALIAS: IP_NCVR_CHRG_AMT
SAS ALIAS: NCCHGAMT
STANDARD ALIAS: NCH_IP_NCOV_CHRG_AMT
TITLE ALIAS: IP_NCOV_CHARGES

DERIVATION:
DERIVED FROM:
  REV_CNTR_CD
  REV_CNTR_NCVR_CHRG_AMT

DERVIATION RULES:
Based on the presence of revenue center code
equal to 0001 move the related noncovered charge
amount to NCH_IP_NCOV_CHRG_AMT.

SOURCE:
NCH QA Process

127. NCH Inpatient Total   PACK   6   651 656   Effective with Version H, the total Part A
    Deduction Amount   deductions reported on the Inpatient claim (used
                                                              for internal CWFMQA editing purposes).

NOTE: During the Version H conversion this field
was populated with data throughout history (back
to 1991), but the derivation rule applied was in-
complete for claims processed prior to 10/93.
Disregard any data present in this field on claims
with NCH weekly process date earlier than 10/93.

9.2 DIGITS SIGNED

DB2 ALIAS: IP_TOT_DDCTN_AMT
SAS ALIAS: TDEDAMT
STANDARD ALIAS: NCH_IP_TOT_DDCTN_AMT
TITLE ALIAS: IP_TOT_DEDUCTIONS

inpatientsnf.txt
```
                            DERIVATION:
                            DERIVED FROM:
                              CLM_VAL_CD
                              CLM_VAL_AMT

                            DERIVATION RULES (Effective 10/93):
                            Accumulate the value amounts associated with
                            value codes equal to 06, 08 thru 11 and A1, B1
                            or C1 and move to IP_TOT_DDCTN_AMT.
                            NOTE:  Value codes 08-11 did not exist in the
                            NCH prior to 2/93; values codes A1, B1, C1 did
                            not exist prior to 10/93.
```

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                     POSITIONS
            NAME              TYPE  LENGTH BEG   END                        CONTENTS
------------------------------ ----  ------ ---------  ------------------------------------------------------------
                                                       SOURCE:
                                                       NCH QA Process

  128. Claim Total PPS Capital  PACK     6   657  662  The total amount that is payable for capital
       Amount                                          PPS for the claim.   This is the sum of the
                                                       capital hospital specific portion, federal
                                                       specific portion, outlier portion,
                                                       disproportionate share portion, indirect
                                                       medical education portion, exception payments,
                                                       and hold harmless payments.

                                                       9.2 DIGITS SIGNED

                                                       DB2 ALIAS: TOT_PPS_CPTL_AMT
                                                       SAS ALIAS: PPS_CPTL
                                                       STANDARD ALIAS: CLM_TOT_PPS_CPTL_AMT
                                                       TITLE ALIAS: PPS_CAPITAL

                                                       COMMENT:
                                                       Prior to Version H the size of this field was:
                                                       S9(7)V99.

                                                       SOURCE:
                                                       CWF
```

129. Claim PPS Capital HSP   PACK   6   663 668 Effective 3/2/92, the hospital specific portion
     Amount   of the PPS payment for capital.

                                                          9.2 DIGITS SIGNED

                                                          DB2 ALIAS: PPS_CPTL_HSP_AMT
                                                          SAS ALIAS: CPTL_HSP
                                                          STANDARD ALIAS: CLM_PPS_CPTL_HSP_AMT
                                                          TITLE ALIAS: PPS_CAPITAL_HSP

                                                          EDIT-RULES:
                                                          $$$$$$$$$CC

                                                          COMMENT:
                                                          Prior to Version H the size of this field was:
                                                          S9(7)V99.

                                                          SOURCE:
                                                          CWF

130. Claim PPS Capital FSP   PACK   6   669 674 Effective 3/2/92, the amount of the federal specific
     Amount   portion of the PPS payment for capital.

                                                          9.2 DIGITS SIGNED

                                                          DB2 ALIAS: PPS_CPTL_FSP_AMT
                                                          SAS ALIAS: CPTL_FSP
                                                          STANDARD ALIAS: CLM_PPS_CPTL_FSP_AMT
                                                          TITLE ALIAS: PPS_CAPITAL_FSP

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                        POSITIONS
              NAME   TYPE LENGTH BEG END   CONTENTS
     ---------------------------- ---- ------ --------- ---

                                                          EDIT-RULES:
                                                          $$$$$$$$$CC

                                                          COMMENT:
                                                          Prior to Version H the size of this field was:
                                                          S9(7)V99.

                                                          SOURCE:

CWF

131. Claim PPS Capital Outlier   PACK   6   675 680   Effective 3/2/92, the amount of the outlier portion
     Amount   of the PPS payment for capital.

                                                           9.2 DIGITS SIGNED

                                                           DB2 ALIAS: PPS_OUTLIER_AMT
                                                           SAS ALIAS: CPTLOUTL
                                                           STANDARD ALIAS: CLM_PPS_CPTL_OUTLIER_AMT
                                                           TITLE ALIAS: PPS_CPTL_OUTLIER

                                                           EDIT-RULES:
                                                           $$$$$$$$$CC

                                                           COMMENT:
                                                           Prior to Version H the size of this field was:
                                                           S9(7)V99.

                                                           SOURCE:
                                                           CWF

132. Claim PPS Capital   PACK   6   681 686   Effective 3/2/92, the amount of disproportionate
     Disproportionate Share   share (rate reflecting indigent population served)
     Amount   portion of the PPS payment for capital.

                                                           9.2 DIGITS SIGNED

                                                           DB2 ALIAS: PPS_DSPRPRTNT_AMT
                                                           SAS ALIAS: DISP_SHR
                                                           STANDARD ALIAS: CLM_PPS_CPTL_DSPRPRTNT_SHR_AMT
                                                           TITLE ALIAS: PPS_DISP_SHR

                                                           EDIT-RULES:
                                                           $$$$$$$$$CC

                                                           COMMENT:
                                                           Prior to Version H the size of the field was:
                                                           S9(7)V99.

                                                           SOURCE:
                                                           CWF

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                    POSITIONS
            NAME              TYPE  LENGTH BEG  END                       CONTENTS
------------------------------ ---- ------ ---------  --------------------------------------------------------------
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133. Claim PPS Capital IME   PACK   6   687 692   Effective 3/2/92, the amount of the indirect medical
     Amount   education (IME) (reimbursable amount for teaching
                                                          hospitals only; an added amount passed by Congress
                                                          to augment normal PPS payments for teaching
                                                          hospitals to compensate them for higher patient
                                                          costs resulting from medical education programs for
                                                          interns and residents) portion of the PPS payment
                                                          for capital.

                                                          9.2 DIGITS SIGNED

                                                          DB2 ALIAS: PPS_CPTL_IME_AMT
                                                          SAS ALIAS: IME_AMT
                                                          STANDARD ALIAS: CLM_PPS_CPTL_IME_AMT
                                                          TITLE ALIAS: PPS_CPTL_IME

                                                          EDIT-RULES:
                                                          $$$$$$$$$CC

                                                          COMMENT:
                                                          Prior to Version H the size of this field was:
                                                          S9(7)V99.

                                                          SOURCE:
                                                          CWF

134. Claim PPS Capital Exception PACK   6   693 698   Effective 3/2/92, the capital PPS amount of
     Amount   exception payments provided for hospitals
                                                          with inordinately high levels of capital
                                                          obligations. Exception payments expire at the
                                                          end of the 10-year transition period.

                                                          9.2 DIGITS SIGNED

                                                          DB2 ALIAS: PPS_EXCPTN_AMT
                                                          SAS ALIAS: CPTL_EXP
                                                          STANDARD ALIAS: CLM_PPS_CPTL_EXCPTN_AMT
                                                          TITLE ALIAS: PPS_CPTL_EXCP

inpatientsnf.txt
EDIT-RULES:
$$$$$$$$$CC

COMMENT:
Prior to Version H the size of this field was:
S9(7)V99.

SOURCE:
CWF

| | | | | POSITIONS | | |
| --- | NAME | TYPE | LENGTH | BEG | END | | CONTENTS |

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS

```
                                          POSITIONS
            NAME             TYPE  LENGTH BEG   END                          CONTENTS
----------------------------  ----  ------ ---------  ------------------------------------------------------------

135. Claim PPS Old Capital Hold  PACK     6   699  704  Effective 3/2/92, this amount is the hold harmless amount
     Harmless Amount                                    payable for old capital as computed by PRICER for
                                                        providers with a payment code equal to 'A'. The hold
                                                        harmless amount-old capital is 100 percent of the
                                                        reasonable costs of old capital for sole community
                                                        sole community hospitals, or 85 percent of
                                                        the reasonable costs associated with old capital for
                                                        all other hospitals, plus a payment for new capital.

                                                        9.2 DIGITS SIGNED

                                                        DB2 ALIAS: PPS_CPTL_HRMLS_AMT
                                                        SAS ALIAS: HLDHRMLS
                                                        STANDARD ALIAS: CLM_PPS_OLD_CPTL_HLD_HRMLS_AMT
                                                        TITLE ALIAS: PPS_CPTL_HOLD_HRMLS

                                                        EDIT-RULES:
                                                        $$$$$$$$$CC

                                                        COMMENT:
                                                        Prior to Version H the size of this field was:
                                                        S9(7)V99.

                                                        SOURCE:
                                                        CWF

136. Claim PPS Capital Discharge  PACK     3   705  707  Effective 3/2/92, the percent resulting from
     Fraction Percent                                   dividing the days by the average length of stay
```

for capital PPS transfer cases (PRICER review
codes 03, 05, 06) not to exceed 1.

1.4 DIGITS SIGNED

DB2 ALIAS: PPS_DSCHRG_PCT
SAS ALIAS: DSCHFRCT
STANDARD ALIAS: CLM_PPS_CPTL_DSCHRG_FRCTN_PCT
TITLE ALIAS: PPS_CAPITL_DSCHRG_FRACTION_PCT

SOURCE:
CWF

137. Claim PPS Capital DRG   PACK   4   708 711   Effective 3/2/92, the number used to determine
     Weight Number   a transfer adjusted case mix index for capital
                                                        PPS. The number is determined by multiplying
                                                        the DRG weight times the discharge fraction.

                                                        3.4 DIGITS SIGNED

                                                        DB2 ALIAS: PPS_DRG_WT_NUM
                                                        SAS ALIAS: DRGWTAMT
                                                        STANDARD ALIAS: CLM_PPS_CPTL_DRG_WT_NUM
                                                        TITLE ALIAS: PPS_CAPITAL_DRG_WEIGHT_NUM

| | | | POSITIONS | | |
NAME	TYPE	LENGTH	BEG	END	CONTENTS

                                                        SOURCE:
                                                        CWF

138. Claim Utilization Day Count PACK   2   712 713   On an institutional claim, the number of
                                                        covered days of care that are chargeable
                                                        to Medicare facility utilization that
                                                        includes full days, coinsurance days, and
                                                        lifetime reserve days.

                                                        3 DIGITS SIGNED

                                                        DB2 ALIAS: CLM_UTLZTN_DAY_CNT
                                                        SAS ALIAS: UTIL_DAY

STANDARD ALIAS: CLM_UTLZTN_DAY_CNT
TITLE ALIAS: UTILIZATION_DAYS

SOURCE:
CWF

139. Claim Cost Report Days   PACK   2   714 715   The number of days on an institutional claim which
     Count   would have been Medicare covered days if another
                                                      primary payer were not involved or if a beneficiary
                                                      had fewer days available than were needed by a PPS
                                                      bill.

                                                      3 DIGITS SIGNED

                                                      DB2 ALIAS: CLM_CR_DAY_CNT
                                                      SAS ALIAS: CR_DAY
                                                      STANDARD ALIAS: CLM_CR_DAY_CNT
                                                      TITLE ALIAS: CR_DAYS

                                                      SOURCE:
                                                      CWF

140. Beneficiary Total   PACK   2   716 717   The count of the total number of coinsurance days
     Coinsurance Days Count   involved with the beneficiary's stay in a facility.

                                                      3 DIGITS SIGNED

                                                      DB2 ALIAS: COINSRNC_DAY_CNT
                                                      SAS ALIAS: COIN_DAY
                                                      STANDARD ALIAS: BENE_TOT_COINSRNC_DAY_CNT
                                                      TITLE ALIAS: COINSRNC_DAYS

                                                      SOURCE:
                                                      CWF

141. Claim Coinsurance Year 1 PACK   2   718 719   Effective with Version H, the count of the number
     Day Count   of coinsurance days during the first year of the
                                                      bill (used for internal CWFMQA editing purposes).

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                              POSITIONS
               NAME   TYPE LENGTH BEG   END   CONTENTS
       ---------------------------- ---- ------ ---------   --

NOTE: Beginning with NCH weekly process date
10/3/97 this field was populated with data.
Claims processed prior to 10/3/97 should contain
zeroes in this field. Exception: during the
Version 'H' conversion invalid data may have
been populated for prior periods. Disregard
any data in this field on claims with NCH
weekly process date earlier than 10/3/97.

3 DIGITS SIGNED

DB2 ALIAS: COINS_YR1_DAY_CNT
SAS ALIAS: COYR1DAY
STANDARD ALIAS: CLM_COINSRNC_YR_1_DAY_CNT
TITLE ALIAS: COINS_YR1_DAYS

SOURCE:
CWF

142. NCH Coinsurance Year 1 Rate PACK   6   720 725   Effective with Version H, the charge for each day
     Amount   of coinsurance during the first year in the bill
                                                           (used for internal CWFMQA editing purposes).

NOTE: Beginning with NCH weekly process date
10/3/97 this field was populated with data.
Claims processed prior to 10/3/97 should contain
zeroes in this field. Exception: during the
Version 'H' conversion invalid data may have been
populated for prior periods.   Disregard any
data present in this field on claims with NCH
weekly process date earlier than 10/3/97.

9.2 DIGITS SIGNED

DB2 ALIAS: COINS_YR1_RATE_AMT
SAS ALIAS: COYR1AMT
STANDARD ALIAS: NCH_COINSRNC_YR_1_RATE_AMT
TITLE ALIAS: COINS_YR1_RATE

DERIVATION:
DERIVED FROM:
  CLM_VAL_CD
  CLM_VAL_AMT

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CLM_COINSRNC_YR_1_DAY_CNT

DERIVATION RULES:
Divide the value amount associated with value code
equal to 09 by the coinsurance year 1 days and move
to NCH_COINSRNC_YR_1_RATE_AMT.

SOURCE:
NCH QA Process

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

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                                           POSITIONS
             NAME              TYPE  LENGTH BEG   END                        CONTENTS
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```

143. Claim Coinsurance Year 2   PACK   2   726 727   Effective with Version H, the count of the
     Day Count   number of coinsurance days during the second
                                                        year of the bill which spans two years (used
                                                        for internal CWFMQA editing purposes.)

                                                        NOTE: Beginning with NCH weekly process date
                                                        10/3/97 this field was populated with data.
                                                        Claims processed prior to 10/3/97 should contain
                                                        zeroes in this field. Exception: during the
                                                        Version 'H' conversion invalid data may have
                                                        been populated for prior periods. Disregard
                                                        any data in this field on claims with NCH
                                                        weekly process date earlier than 10/3/97.

                                                        3 DIGITS SIGNED

                                                        DB2 ALIAS: COINS_YR2_DAY_CNT
                                                        SAS ALIAS: COYR2DAY
                                                        STANDARD ALIAS: CLM_COINSRNC_YR_2_DAY_CNT
                                                        TITLE ALIAS: COINS_YR2_DAYS

                                                        SOURCE:
                                                        CWF

144. NCH Coinsurance Year 2 Rate PACK   6   728 733   Effective with Version H, the charge for each
     Amount   day of coinsurance during the second year in a
                                                        bill which spans two years (used for internal
                                                        CWFMQA editing purposes.)

NOTE: Beginning with NCH weekly process date
10/3/97 this field was populated with data.
Claims processed prior to 10/3/97 should contain
zeroes in this field. Exception: during the
Version 'H' conversion invalid data may have
been populated for prior periods. Disregard
any data in this field on claims with NCH
weekly process date earlier than 10/3/97.

9.2 DIGITS SIGNED

DB2 ALIAS: COINS_YR2_RATE_AMT
SAS ALIAS: COYR2AMT
STANDARD ALIAS: NCH_COINSRNC_YR_2_RATE_AMT
TITLE ALIAS: COINS_YR2_RATE

DERIVATION:
DERIVED FROM:
  CLM_VAL_CD
  CLM_VAL_AMT
  CLM_COINSRNC_YR_2_DAY_CNT

DERIVATION RULES:
Divide the value amount associated with value code
equal to 11 by the coinsurance year 2 days and move
to NCH_COINSRNC_YR_2_RATE_AMT.

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

| | | | POSITIONS | | |
NAME	TYPE	LENGTH	BEG	END	CONTENTS
					SOURCE: NCH QA Process
145. Beneficiary LRD Used Count	PACK	2	734	735	The number of lifetime reserve days that the beneficiary has elected to use during the period covered by the institutional claim. Under Medicare, each beneficiary has a one-time reserve of sixty additional days of inpatient hospital coverage that can be used after 90 days of inpatient care have been provided in a single benefit period. This count is used to subtract from the total

inpatientsnf.txt
number of lifetime reserve days that a beneficiary
has available.

3 DIGITS SIGNED

DB2 ALIAS: BENE_LRD_USE_CNT
SAS ALIAS: LRD_USE
STANDARD ALIAS: BENE_LRD_USE_CNT
TITLE ALIAS: LRD_USED

SOURCE:
CWF

146. Claim Non Utilization Days   PACK   3   736   738   On an institutional claim, the number of days of
     Count   care that are not chargeable to Medicare facility
                                                             utilization.

5 DIGITS SIGNED

DB2 ALIAS: NUTLZTN_DAY_CNT
SAS ALIAS: NUTILDAY
STANDARD ALIAS: CLM_NUTLZTN_DAY_CNT
TITLE ALIAS: NUTLZTN_DAYS

SOURCE:
CWF

147. Beneficiary Prior   PACK   2   739   740   Effective with Version H, the number of days
     Psychiatric Day Count   in a psychiatric hospital prior to the
                                                            entitlement to Medicare.

NOTE: Beginning with NCH weekly process date
10/3/97 this field was populated with data.
Claims processed prior to 10/3/97 will contain
zeroes in this field.

3 DIGITS SIGNED

DB2 ALIAS: PRIOR_PSYCH_CNT
SAS ALIAS: PSYCHDAY
STANDARD ALIAS: BENE_PRIOR_PSYCH_DAY_CNT
TITLE ALIAS: PRIOR_PSYCH_DAYS

```
                                         POSITIONS
          NAME              TYPE  LENGTH BEG   END                        CONTENTS
------------------------    ----  ------ ---------   --------------------------------------------------------
```

                                                     SOURCE:
                                                     CWF

148. NCH Blood Pints Furnished   PACK   2   741   742   Number of whole pints of blood furnished to the
     Quantity   beneficiary.

                                                     3 DIGITS SIGNED

                                                     DB2 ALIAS: NCH_BLOOD_PT_FRNSH
                                                     SAS ALIAS: BLDFRNSH
                                                     STANDARD ALIAS: NCH_BLOOD_PT_FRNSH_QTY
                                                     TITLE ALIAS: BLOOD_PINTS_FURNISHED

                                                     EDIT-RULES:
                                                     NUMERIC

                                                     DERIVATION:
                                                     DERIVED FROM:
                                                       CLM_VAL_CD
                                                       CLM_VAL_AMT

                                                     DERIVATION RULES:
                                                     Based on the presence of value code equal to
                                                     37 move the related value amount to the
                                                     NCH_BLOOD_PT_FRNSH_QTY.

                                                     COMMENT:
                                                     Prior to Version H this field was named:
                                                     CLM_BLOOD_PT_FRNSH_QTY. Also for outpatient
                                                     claims this field was stored in a blood
                                                     trailer. Version H eliminated the outpatient
                                                     blood trailer.

                                                     SOURCE:
                                                     NCH QA Process

149. NCH Blood Pints Replaced   PACK   2   743   744   Number of whole pints of blood replaced.
     Quantity
                                                     3 DIGITS SIGNED

DB2 ALIAS: BLOOD_PT_RPLC_QTY
SAS ALIAS: BLD_RPLC
STANDARD ALIAS: NCH_BLOOD_PT_RPLC_QTY
TITLE ALIAS: BLOOD_PINTS_REPLACED

EDIT-RULES:
NUMERIC

DERIVATION:
DERIVED FROM:
  CLM_VAL_CD
  CLM_VAL_AMT

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

| | | POSITIONS | | |
NAME	TYPE	LENGTH	BEG	END	CONTENTS

DERIVATION RULES:
Based on the presence of value code equal to
39 move the related value amount to the
NCH_BLOOD_PT_RPLC_QTY.

COMMENT:
Prior to Version H this field was named:
CLM_BLOOD_PT_RPLC_QTY. Also for outpatient
claims this field was stored in a blood
trailer. Version H eliminated the outpatient
blood trailer.

SOURCE:
NCH QA Process

150. NCH Blood Pints Not   PACK   2   745 746   Number of whole pints of blood not replaced.
     Replaced Quantity

3 DIGITS SIGNED

DB2 ALIAS: BLOOD_PT_NRPLC_QTY
SAS ALIAS: BLDNRPLC
STANDARD ALIAS: NCH_BLOOD_PT_NRPLC_QTY
TITLE ALIAS: BLOOD_PINTS_NOT_REPLACED

EDIT-RULES:
NUMERIC

DERIVATION:
DERIVED FROM:
  CLM_VAL_CD
  CLM_VAL_AMT

DERIVATION RULES:
Subtract value code 39 amount from value code
37 amount and move the result to
NCH_BLOOD_PT_NRPLC_QTY.

COMMENT:
Prior to Version H this field was named:
CLM_BLOOD_PT_NRPLC_QTY. Also for outpatient
claims this field was stored in a blood
trailer. Version H eliminated the outpatient
blood trailer.

SOURCE:
NCH QA Process

151. NCH Blood Deductible Pints   PACK   2   747 748   The quantity of blood pints applied (blood
     Quantity   deductible).

                                                             3 DIGITS SIGNED

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                                POSITIONS
             NAME   TYPE   LENGTH BEG   END   CONTENTS
     ----------------------------   ----   ------ ---------   ---

                                                             DB2 ALIAS: BLOOD_DDCTBL_QTY
                                                             SAS ALIAS: BLDDEDPT
                                                             STANDARD ALIAS: NCH_BLOOD_DDCTBL_PT_QTY
                                                             TITLE ALIAS: BLOOD_PINTS_DEDUCTIBLE

                                                             EDIT-RULES:
                                                             NUMERIC

inpatientsnf.txt
DERIVATION:
DERIVED FROM:
  CLM_VAL_CD
  CLM_VAL_AMT

DERIVATION RULES:
Based on the presence of value code equal to
38 move the related value amount to the
NCH_BLOOD_DDCTBL_PT_QTY.

COMMENT:
Prior to Version H this field was named:
CLM_BLOOD_DDCTBL_PT_QTY. Also for outpatient
claims this field was stored in a blood
trailer. Version H eliminated the outpatient
blood trailer.

SOURCE:
NCH QA Process

152. NCH Qualified Stay From   NUM   8   749 756   Effective with Version H, the beginning date of
     Date   the beneficiary's qualifying stay (used for internal
                                                              CWFMQA editing purposes). For inpatient claims, the
                                                              date relates to the PPS portion of the inlier for
                                                              which there is no utilization to benefits. For
                                                              SNF claims, the date relates to a qualifying stay
                                                              from a hospital that is at least two days in a row
                                                              if the source of admission is an 'A', or at least
                                                              three days in a row if the source of admission
                                                              is other than 'A'.

                                                              NOTE: During the Version H conversion this field
                                                              was populated with data throughout history (back to
                                                              service year 1991).

                                                              8 DIGITS UNSIGNED

                                                              DB2 ALIAS: QLFY_STAY_FROM_DT
                                                              SAS ALIAS: QLFYFROM
                                                              STANDARD ALIAS: NCH_QLFY_STAY_FROM_DT
                                                              TITLE ALIAS: QLFYG_STAY_FROM_DT

                                                              EDIT-RULES:

```
                                        POSITIONS
            NAME                TYPE  LENGTH BEG  END                        CONTENTS
----------------------------    ----  ------ ---------  ------------------------------------------------------------
```

                                                         DERIVATION:
                                                         DERIVED FROM:
                                                           CLM_OCRNC_SPAN_CD
                                                           CLM_OCRNC_SPAN_FROM_DT

                                                         DERIVATION RULES:
                                                         Based on the presence of occurrence code 70
                                                         move the related occurrence from date to
                                                         NCH_QLFY_STAY_FROM_DT.

                                                         SOURCE:
                                                         NCH QA Process

153. NCH Qualify Stay Through   NUM   8   757 764   Effective with Version H, the ending date of
     Date   the beneficiary's qualifying stay (used for internal
                                                          CWFMQA editing purposes.)   For inpatient claims, the
                                                          date relates to the PPS portion of the inlier for
                                                          which there is no utilization to benefits. For
                                                          SNF claims, the date relates to a qualifying stay
                                                          from a hospital that is at least two days in a row
                                                          if the source of admission is an 'A', or at least
                                                          three days in a row if the source of admission
                                                          is other than 'A'.

                                                         NOTE: During the Version H, conversion this field
                                                         was populated with data throughout history (back to
                                                         service year 1991).

                                                         8 DIGITS UNSIGNED

                                                         DB2 ALIAS: QLFY_STAY_THRU_DT
                                                         SAS ALIAS: QLFYTHRU
                                                         STANDARD ALIAS: NCH_QLFY_STAY_THRU_DT
                                                         TITLE ALIAS: QLFYG_STAY_THRU_DT

                                                         EDIT-RULES:

```
                              inpatientsnf.txt
                         YYYYMMDD

                         DERIVATION:
                         DERIVED FROM:
                           CLM_OCRNC_SPAN_CD
                           CLM_OCRNC_SPAN_THRU_DT

                         DERIVATION RULES:
                         Based on the presence of occurrence code 70
                         move the related occurrence thru date to
                         NCH_QLFY_STAY_THRU_DT.

                         SOURCE:
                         NCH QA Process

  154. NCH Verified Noncovered      NUM      8   765  772  Effective with Version H, the beginning date of
       Stay From Date                                      the beneficiary's noncovered stay (used for
                                                           internal CWFMQA editing purposes.)
```

```
                                      POSITIONS
            NAME                TYPE  LENGTH BEG  END                        CONTENTS
   ----------------------------  ----  ------ ---------  -------------------------------------------------------
                                                         NOTE:  During the Version H conversion this field
                                                         was populated with data throughout history (back to
                                                         service year 1991).

                                                         8 DIGITS UNSIGNED

                                                         DB2 ALIAS: VRFY_NCVR_FROM_DT
                                                         SAS ALIAS: NCOVFROM
                                                         STANDARD ALIAS: NCH_VRFY_NCOV_STAY_FROM_DT
                                                         TITLE ALIAS: VERIFIED_NCOV_FROM_DT

                                                         EDIT-RULES:
                                                         YYYYMMDD

                                                         DERIVATION:
                                                         DERIVED FROM:
                                                           CLM_OCRNC_SPAN_CD
                                                           CLM_OCRNC_SPAN_FROM_DT
```

```
                         inpatientsnf.txt
                  DERIVATION RULES:
                  Based on the presence of occurrence code 74, 76,
                  77 or 79 move the related occurrence from date to
                  NCH_VRFY_NCOV_STAY_FROM_DT.

                  SOURCE:
                  NCH QA Process

155. NCH Verified Noncovered      NUM      8  773 780  Effective with Version H, the ending date of
     Stay Through Date                                 the beneficiary's noncovered stay (used for
                                                       internal CWFMQA editing purposes.)

                                                       NOTE:  During the Version H conversion this field
                                                       was populated with data throughout history (back to
                                                       service year 1991).

                                                       8 DIGITS UNSIGNED

                                                       DB2 ALIAS: VRFY_NCVR_THRU_DT
                                                       SAS ALIAS: NCOVTHRU
                                                       STANDARD ALIAS: NCH_VRFY_NCOV_STAY_THRU_DT
                                                       TITLE ALIAS: VERIFIED_NCOV_THRU_DT

                                                       EDIT-RULES:
                                                       YYYYMMDD

                                                       DERIVATION:
                                                       DERIVED FROM:
                                                         CLM_OCRNC_SPAN_CD
                                                         CLM_OCRNC_SPAN_THRU_DT

                                                       DERIVATION RULES:
                                                       Based on the presence of occurrence code 74, 76,
                                                       77 or 79 move the related occurrence thru date to
                                                       NCH_VRFY_NCOV_STAY_THRU_DT.
```

```
                           POSITIONS
           NAME              TYPE  LENGTH BEG  END                        CONTENTS
    -----------------------  ----  ------ ---------  ------------------------------------------------------

                                                       SOURCE:
                                                       NCH QA Process
```

156. NCH Provider Guaranteed   NUM   8   781   788   The date that the guaranteed payment to the
     Payment Start Date   institutional provider started.

                                            8 DIGITS UNSIGNED

                                            DB2 ALIAS: GUARNT_PMT_STRT_DT
                                            SAS ALIAS: GURPMTDT
                                            STANDARD ALIAS: NCH_PRVDR_GUARNT_PMT_STRT_DT
                                            TITLE ALIAS: GARNT_PMT_DT

                                            EDIT-RULES:
                                            YYYYMMDD

                                            DERIVATION:
                                            DERIVED FROM:
                                              CLM_RLT_OCRNC_CD
                                              CLM_RLT_OCRNC_DT

                                            DERIVATION RULES:
                                            Based on the presence of occurrence code 20
                                            move the related occurrence date to
                                            NCH_PRVDR_GUARNT_PMT_STRT_DT.

                                            COMMENT:
                                            Prior to Version H this field was named:
                                            CLM_PRVDR_GUARNT_PMT_STRT_DT.

                                            SOURCE:
                                            NCH QA Process

157. NCH Utilization Review   NUM   8   789   796   The date of receipt by the skilled nursing
     Notice Received Date   facility of a utilization review committee's
                                            finding that an admission or further stay was no
                                          longer medically necessary.

                                            8 DIGITS UNSIGNED

                                          DB2 ALIAS: NCH_UR_NTC_RCV_DT
                                          SAS ALIAS: URNTCDT
                                          STANDARD ALIAS: NCH_UR_NTC_RCV_DT
                                          TITLE ALIAS: UR_NTC_RCV_DT

                                          EDIT-RULES:

YYYYMMDD

DERIVATION:
DERIVED FROM:
  CLM_RLT_OCRNC_CD
  CLM_RLT_OCRNC_DT

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```
                              POSITIONS
          NAME          TYPE  LENGTH BEG  END                        CONTENTS
---------------------------   ----  ------ ---------   --------------------------------------------------------
```

                                              DERIVATION RULES:
                                              Based on the presence of occurrence code 21
                                              move the related occurrence date to
                                              NCH_UR_NTC_RCV_DT.

                                              COMMENT:
                                              Prior to Version H this field was named:
                                              CLM_UR_NTC_RCV_DT.

                                              SOURCE:
                                              NCH QA Process

158. NCH Active or Covered Level NUM   8   797 804   The date on a claim for which the covered level of
     Care Thru Date   care ended in a general hospital or the active care
                                                         ended in a psychiatric/TB hospital.

                                              8 DIGITS UNSIGNED

                                              DB2 ALIAS: ACTV_CARE_THRU_DT
                                              SAS ALIAS: CARETHRU
                                              STANDARD ALIAS: NCH_ACTV_CVR_LVL_CARE_THRU_DT
                                              TITLE ALIAS: ACTIVE_CARE_THRU_DT

                                              EDIT-RULES:
                                              YYYYMMDD

                                              DERIVATION:
                                              DERIVED FROM:
                                                CLM_RLT_OCRNC_CD
                                                CLM_RLT_OCRNC_DT

inpatientsnf.txt
                         DERIVATION RULES:
                         Based on the presence of occurrence code 22
                         move the related occurrence date to
                         NCH_ACTV_CVR_LVL_CARE_THRU_DT.

                         COMMENT:
                         Prior to Version H this field was named:
                         CLM_ACTV_CVR_LVL_CARE_THRU_DT.

                         SOURCE:
                         NCH QA Process

   159. NCH Beneficiary Medicare   NUM   8   805 812   The last date for which the beneficiary has
        Benefits Exhausted Date   Medicare coverage. This is completed only where
                                                           where benefits were exhausted before the date of
                                                           discharge and during the billing period covered
                                                           by this institutional claim.

                                                           8 DIGITS UNSIGNED

                                POSITIONS
            NAME   TYPE LENGTH BEG END   CONTENTS
   --------------------------- ---- ------ --------- --

                                                     DB2 ALIAS: MDCR_BNFT_EXHST_DT
                                                     SAS ALIAS: EXHST_DT
                                                     STANDARD ALIAS: NCH_MDCR_BNFT_EXHST_DT
                                                     TITLE ALIAS: BENEFIT_EXHST_DT

                                                     EDIT-RULES:
                                                     YYYYMMDD

                                                     DERIVATION:
                                                     DERIVED FROM:
                                                       CLM_RLT_OCRNC_CD
                                                       CLM_RLT_OCRNC_DT

                                                     DERIVATION RULES (Effective 10/93):
                                                     Based on the presence of occurrence code A3,
                                                     B3 or C3 move the related occurrence date to
                                                     NCH_MDCR_BNFT_EXHST_DT. *NOTE: Prior to
                                                     10/93, the date associated with occurrence

```
                                inpatientsnf.txt
                                code 23 was moved to this field.

                                COMMENT:
                                Prior to Version H this field was named:
                                CLM_MDCR_BNFT_EXHST_DT.

                                SOURCE:
                                NCH QA Process

    160. NCH Beneficiary Discharge    NUM      8   813  820   Effective with Version H, on an inpatient and
         Date                                                 HHA claim, the date the beneficiary was discharged
                                                              from the facility or died (used for internal CWFMQA
                                                              editing purposes.)

                                                              NOTE:  During the Version H conversion this field
                                                              was populated with data throughout history (back to
                                                              service year 1991.)

                                                              8 DIGITS UNSIGNED

                                                              DB2 ALIAS: NCH_BENE_DSCHRG_DT
                                                              SAS ALIAS: DSCHRGDT
                                                              STANDARD ALIAS: NCH_BENE_DSCHRG_DT
                                                              TITLE ALIAS: DISCHARGE_DT

                                                              EDIT-RULES:
                                                              YYYYMMDD

                                                              DERIVATION:
                                                              DERIVED FROM:
                                                                NCH_PTNT_STUS_IND_CD
                                                                CLM_THRU_DT

                                                              DERIVATION RULES:
                                                              Based on the presence of patient discharge status
                                                              code not equal to 30 (still patient), move the claim
                                                              thru date to the NCH_BENE_DSCHRG_DT.
```

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

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                                      POSITIONS
            NAME                TYPE   LENGTH BEG  END                          CONTENTS
    ----------------------------  ----  ------ ---------  ------------------------------------------------------------

                                                              SOURCE:
```

161. Claim Diagnosis Related   CHAR   3   821 823   The diagnostic related group to which a hospital
     Group Code   claim belongs for prospective payment purposes.

                                                        COMMON ALIAS: DRG
                                                        DB2 ALIAS: CLM_DRG_CD
                                                        SAS ALIAS: DRG_CD
                                                        STANDARD ALIAS: CLM_DRG_CD
                                                        TITLE ALIAS: DRG

                                                        EDIT-RULES:
                                                        DRG DEFINITIONS MANUAL

                                                        COMMENT:
                                                        GROUPER is the software that determines the DRG
                                                        from data elements reported by the hospital.
                                                        Once determined, the DRG code is one of the
                                                        elements used to determine the price upon which
                                                        to base the reimbursement to the hospitals
                                                        under prospective payment. Nonpayment claims
                                                        (zero reimbursement) may not have a DRG present.

                                                        SOURCE:
                                                        CWF

162. Claim Diagnosis Related   CHAR   1   824 824   On an institutional claim, the code that
     Group Outlier Stay Code   indicates the beneficiary stay under the
                                                        prospective payment system which, although
                                                        classified into a specific diagnosis related
                                                        group, has an unusually long length (day
                                                        outlier) or exceptionally high cost
                                                        (cost outlier).

                                                        DB2 ALIAS: DRG_OUTLIER_CD
                                                        SAS ALIAS: OUTLR_CD
                                                        STANDARD ALIAS: CLM_DRG_OUTLIER_STAY_CD
                                                        TITLE ALIAS: DRG_OUTLIER_STAY_CODE

                                                        CODES:
                                                          REFER TO: DRG_OUTLIER_STAY_TB
                                                                    IN THE CODES APPENDIX

                                                        SOURCE:

CWF

163. NCH DRG Outlier Approved   PACK   6   825 830 On an institutional claim, the additional
     Payment Amount   payment amount approved by the Peer Review
                                                          Organization due to an outlier situation for
                                                          a beneficiary's stay under the prospective
                                                          payment system, which has been classified
                                                          into a specific diagnosis related group.

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                         POSITIONS
              NAME   TYPE LENGTH BEG END   CONTENTS
     --------------------------- ---- ------ -------- --
                                                         9.2 DIGITS SIGNED

                                                         DB2 ALIAS: DRG_OUTLIER_AMT
                                                         SAS ALIAS: OUTLRPMT
                                                         STANDARD ALIAS: NCH_DRG_OUTLIER_APRV_PMT_AMT
                                                         TITLE ALIAS: DRG_OUTLIER_PMT

                                                         DERIVATION:
                                                         DERIVED FROM:
                                                           CLM_VAL_CD
                                                           CLM_VAL_AMT

                                                         DERIVATION RULES:
                                                         Based on the presence of value code equal
                                                         to 17 move the related amount to
                                                         NCH_DRG_OUTLIER_APRV_PMT_AMT.

                                                         COMMENT:
                                                         Prior to Version H this field was named:
                                                         CLM_DRG_OUTLIER_APRV_PMT_AMT and field size
                                                         was S9(7)V99.

                                                         SOURCE:
                                                         NCH QA Process

164. Claim KRON Indicator Code   CHAR   1   831 831 Effective with Version H, on inpatient claims
                                                          only, the code indicating that the bill must force
                                                          a new spell even if it is within 60 days of a
                                                          prior spell.

NOTE: Beginning with NCH weekly process date
10/3/97 this field was populated with data.
Claims processed prior to 10/3/97 will contain
spaces in this field.

DB2 ALIAS: CLM_KRON_IND_CD
SAS ALIAS: KRON_IND
STANDARD ALIAS: CLM_KRON_IND_CD
TITLE ALIAS: KRON_IND

CODES:
K = Bill must force a new spell even
    if it is within 60 days of a prior
    spell
Blank = spell is not forced

SOURCE:
CWF

```
  165. FILLER                      CHAR    24   832  855

 ****  FI Inpatient SNF Claim      GROUP   VAR           Variable portion of the fiscal intermediary inpatient/
       Variable Group                                    SNF claim record for version H of the NCH.
```

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                     POSITIONS
            NAME               TYPE  LENGTH BEG  END                              CONTENTS
   --------------------------  ----  ------ ---------  ----------------------------------------------------------
```

STANDARD ALIAS: FI_IP_SNF_CLM_VAR_GRP

```
 ****  NCH Edit Group             GROUP     5          The number of claim edit trailers is determined
                                                       by the claim edit code count.
```

OCCURS: UP TO 13 TIMES
        DEPENDING ON IP_NCH_EDIT_CD_CNT

STANDARD ALIAS: NCH_EDIT_GRP

```
  166. NCH Edit Trailer Indicator  CHAR     1          Effective with Version H, the code indicating
       Code                                            the presence of an NCH edit trailer.
```

inpatientsnf.txt
NOTE: During the Version H conversion this field
was populated throughout history (back to service
year 1991).

DB2 ALIAS: EDIT_TRLR_IND_CD
SAS ALIAS: EDITIND
STANDARD ALIAS: NCH_EDIT_TRLR_IND_CD

CODES:
E = Edit code trailer present

SOURCE:
NCH QA Process

167. NCH Edit Code   CHAR   4   The code annotated to the claim indicating
                                                        the CWFMQA editing results so users will
                                                        be aware of data deficiencies.

                                                        NOTE: Prior to Version H only the highest
                                                        priority code was stored. Beginning 11/98
                                                        up to 13 edit codes may be present.

                                                        COMMON ALIAS: QA_ERROR_CODE
                                                        DB2 ALIAS: NCH_EDIT_CD
                                                        SAS ALIAS: EDIT_CD
                                                        STANDARD ALIAS: NCH_EDIT_CD
                                                        TITLE ALIAS: QA_ERROR_CD

                                                        CODES:
                                                          REFER TO: NCH_EDIT_TB
                                                                    IN THE CODES APPENDIX

                                                        SOURCE:
                                                        NCH QA EDIT PROCESS

****   NCH Patch Group   GROUP   11   OCCURS: UP TO 30 TIMES
                                                                DEPENDING ON IP_NCH_PATCH_CD_I_CNT

                                                        STANDARD ALIAS: NCH_PATCH_GRP

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                          POSITIONS
                 NAME   TYPE LENGTH BEG END   CONTENTS

                                                   Page 99

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    -------------------------  ----  ------ --------   ------------------------------------------------------------
```

168. NCH Patch Trailer Indicator   CHAR   1   Effective with Version H, the code indicating
     Code   the presence of an NCH patch trailer.

                                                         NOTE: During the Version H conversion this field
                                                         was populated throughout history (back to service
                                                         year 1991).

                                                         DB2 ALIAS: PATCH_TRLR_IND_CD
                                                         SAS ALIAS: PATCHIND
                                                         STANDARD ALIAS: NCH_PATCH_TRLR_IND_CD

                                                         CODES:
                                                         P = Patch code trailer present

                                                         SOURCE:
                                                         NCH

169. NCH Patch Code   CHAR   2   Effective with Version H, the code annotated
                                                         to the claim indicating a patch was applied
                                                         to the record during an NCH Nearline record
                                                         conversion and/or during current processing.

                                                         NOTE: Prior to Version H this field was located
                                                         in the third and fourth occurrence of the
                                                         CLM_EDIT_CD.

                                                         DB2 ALIAS: NCH_PATCH_CD
                                                         SAS ALIAS: PATCHCD
                                                         STANDARD ALIAS: NCH_PATCH_CD
                                                         TITLE ALIAS: NCH_PATCH

                                                         CODES:
                                                           REFER TO: NCH_PATCH_TB
                                                                     IN THE CODES APPENDIX

                                                         SOURCE:
                                                         NCH

170. NCH Patch Applied Date   NUM   8   Effective with Version H, the date the NCH patch
                                                         was applied to the claim.

```
                           inpatientsnf.txt
                          8 DIGITS UNSIGNED

                          DB2 ALIAS: NCH_PATCH_APPLY_DT
                          SAS ALIAS: PATCHDT
                          STANDARD ALIAS: NCH_PATCH_APPLY_DT
                          TITLE ALIAS: NCH_PATCH_DT

                          EDIT-RULES:
                          YYYYMMDD

                          SOURCE:
                          NCH
```

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                    POSITIONS
              NAME            TYPE  LENGTH BEG  END                         CONTENTS
   ---------------------------- ----  ------ ---------  ------------------------------------------------------------

 ****  MCO Period Group         GROUP   37               The number of managed care organization (MCO)
                                                         period data trailers present is determined by
                                                         the claim MCO period trailer count.  This field
                                                         reflects the two most current MCO periods in the
                                                         CWF beneficiary history record.  It may have no
                                                         connection to the services on the claim.

                                                         OCCURS: UP TO 2 TIMES
                                                                 DEPENDING ON IP_MCO_PRD_CNT

                                                         STANDARD ALIAS: MCO_PRD_GRP

  171. NCH MCO Trailer Indicator CHAR    1               Effective with Version H, the code indicating
       Code                                              the presence of a Managed Care Organization (MCO)
                                                         trailer.

                                                         NOTE:  Beginning with NCH weekly process date
                                                         10/3/97 this field was populated with data.
                                                         Claims processed prior to 10/3/97 will contain
                                                         spaces in this field.

                                                         COBOL ALIAS: MCO_IND
                                                         DB2 ALIAS: MCO_TRLR_IND_CD
                                                         SAS ALIAS: MCOIND
                                                         STANDARD ALIAS: NCH_MCO_TRLR_IND_CD

                                    Page 101
```

TITLE ALIAS: MCO_INDICATOR

CODES:
M = MCO trailer present

SOURCE:
NCH QA Process

172. MCO Contract Number   CHAR   5   Effective with Version H, this field represents
                                                    the plan contract number of the Managed Care
                                                    Organization (MCO).

                                                    NOTE: Beginning with NCH weekly process date
                                                    10/3/97 this field was populated with data.
                                                    Claims processed prior to 10/3/97 will contain
                                                    spaces in this field.

                                                    DB2 ALIAS: MCO_CNTRCT_NUM
                                                    SAS ALIAS: MCONUM
                                                    STANDARD ALIAS: MCO_CNTRCT_NUM
                                                    TITLE ALIAS: MCO_NUM

                                                    SOURCE:
                                                    CWF

173. MCO Option Code   CHAR   1   Effective with Version H, the code indicating
                                                    Managed Care Organization (MCO) lock-in
                                                    enrollment status of the beneficiary.

| | | | POSITIONS | |
NAME	TYPE	LENGTH	BEG END	CONTENTS

                                                    NOTE: Beginning with NCH weekly process date
                                                    10/3/97 this field was populated with data.
                                                    Claims processed prior to 10/3/97 will contain
                                                    spaces in this field.

                                                    DB2 ALIAS: MCO_OPTN_CD
                                                    SAS ALIAS: MCOOPTN
                                                    STANDARD ALIAS: MCO_OPTN_CD
                                                    TITLE ALIAS: MCO_OPTION_CD

CODES:
*****For lock-in beneficiaries****
A = HCFA to process all provider bills
B = MCO to process only in-plan
C = MCO to process all Part A and Part B bills

***** For non-lock-in beneficiaries*****
1 = HCFA to process all provider bills
2 = MCO to process only in-plan Part A and
    Part B bills

SOURCE:
CWF

174. MCO Period Effective Date   NUM   8   Effective with Version H, the date the bene-
                                                      ficiary's enrollment in the Managed Care
                                                      Organization (MCO) became effective.

                                                      NOTE: Beginning with NCH weekly process date
                                                      10/3/97 this field was populated with data.
                                                      Claims processed prior to 10/3/97 will contain
                                                      zeroes in this field.

                                                      8 DIGITS UNSIGNED

                                                      DB2 ALIAS: MCO_PRD_EFCTV_DT
                                                      SAS ALIAS: MCOEFFDT
                                                      STANDARD ALIAS: MCO_PRD_EFCTV_DT
                                                      TITLE ALIAS: MCO_PERIOD_EFF_DT

                                                      EDIT-RULES:
                                                      YYYYMMDD

                                                      SOURCE:
                                                      CWF

175. MCO Period Termination Date NUM   8   Effective with Version H, the date the bene-
                                                      ficiary's enrollment in the Managed Care
                                                      Organization (MCO) was terminated.

                                                      NOTE: Beginning with NCH weekly process date
                                                      10/3/97 this field was populated with data.
                                                      Claims processed prior to 10/3/97 will contain

zeroes in this field.

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```
                                         POSITIONS
             NAME             TYPE  LENGTH BEG   END                              CONTENTS
    ---------------------------  ----  ------ ---------    ------------------------------------------------------------
                                                           8 DIGITS UNSIGNED

                                                           DB2 ALIAS: MCO_PRD_TRMNTN_DT
                                                           SAS ALIAS: MCOTRMDT
                                                           STANDARD ALIAS: MCO_PRD_TRMNTN_DT
                                                           TITLE ALIAS: MCO_PERIOD_TERM_DT

                                                           EDIT-RULES:
                                                           YYYYMMDD

                                                           SOURCE:
                                                           CWF

    176. MCO Health PLANID Number   CHAR     14            A placeholder field (effective with Version H)
                                                           for storing the Health PlanID associated with
                                                           the Managed Care Organization (MCO).  Prior to
                                                           Version 'I' this field was named:
                                                           MCO_PAYERID_NUM.

                                                           DB2 ALIAS: MCO_PLANID_NUM
                                                           SAS ALIAS: MCOPLNID
                                                           STANDARD ALIAS: MCO_HLTH_PLANID_NUM
                                                           TITLE ALIAS: MCO_PLANID

                                                           COMMENT:
                                                           Prior to Version I this field was named:
                                                           MCO_PAYERID_NUM.

                                                           SOURCE:
                                                           CWF

    ****  Claim Health PlanID Group  GROUP    16           The number of Health PlanID data trailers is determined
                                                           by the claim Health PlanID trailer count.  Prior
                                                           to Version 'I' this field was named:
                                                           CLM_PAYERID_GRP.
```

```
                                inpatientsnf.txt
                         OCCURS: UP TO 3 TIMES
                                 DEPENDING ON IP_CLM_HLTH_PLANID_CNT

                         STANDARD ALIAS: CLM_HLTH_PLANID_GRP

   177. NCH Health PlanID Trailer    CHAR      1          A placeholder field (effective with Version H)
        Indicator Code                                    for storing the code that indicates the presence
                                                          of a Health PlanID trailer.  NOTE: Prior to
                                                          Version 'I' this field was named:
                                                          NCH_PAYERID_TRLR_IND_CD.

                                                          DB2 ALIAS: PLANID_TRLR_CD
                                                          SAS ALIAS: PLANIDIN
                                                          STANDARD ALIAS: NCH_HLTH_PLANID_TRLR_IND_CD

                                                          CODES:
                                                          I = Health PlanID trailer present

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                                             POSITIONS
                 NAME                TYPE  LENGTH BEG   END                          CONTENTS
        ----------------------------  ----  ------ ---------  -------------------------------------------------------------

                                                          COMMENT:
                                                          Prior to Version I this field was named:
                                                          NCH_PAYERID_TRLR_IND_CD.

                                                          SOURCE:
                                                          NCH

   178. Claim Health PlanID Code     CHAR      1          A placeholder field (effective with Version H)
                                                          for storing the code identifying the type of
                                                          Health PlanID.  Prior to Version 'I' this field
                                                          was named: CLM_PAYERID-CD

                                                          DB2 ALIAS: CLM_PLANID_CD
                                                          SAS ALIAS: PLANIDCD
                                                          STANDARD ALIAS: CLM_HLTH_PLANID_CD
                                                          TITLE ALIAS: PLANID_TYPE

                                                          CODES:
                                                          1 = Medicare Secondary Payer
                                                          2 = Medicaid

                                Page 105
```

```
                                   inpatientsnf.txt
                                3 = Medigap
                                4 = Supplemental Insurer
                                5 = Managed Care Organization

                                COMMENT:
                                Prior to Version I this field was named:
                                CLM_PAYERID_CD.

                                SOURCE:
                                CWF

  179. Claim Health PlanID Number   CHAR    14       A placeholder field (effective with Version H)
                                                     for storing the Health PlanID number.  Prior
                                                     to Version 'I' this field was named:
                                                     CLM_PAYERID_NUM.

                                                     DB2 ALIAS: CLM_PLANID_NUM
                                                     SAS ALIAS: PLANID
                                                     STANDARD ALIAS: CLM_HLTH_PLANID_NUM
                                                     TITLE ALIAS: PLANID

                                                     COMMENT:
                                                     Prior to Version I this field was named:
                                                     CLM_PAYERID_NUM.

                                                     SOURCE:
                                                     CWF

 ****  Claim Demonstration          GROUP   18       The number of demonstration identification
       Identification Group                          trailers present is determined by the claim
                                                     demonstration identification trailer count.
```

```
                                         POSITIONS
            NAME              TYPE  LENGTH BEG   END                      CONTENTS
  --------------------------- ----  ------ ---------  ----------------------------------------------------------

                                                     OCCURS: UP TO 5 TIMES
                                                          DEPENDING ON IP_CLM_DEMO_ID_CNT

                                                     STANDARD ALIAS: CLM_DEMO_ID_GRP

  180. NCH Demonstration Trailer   CHAR    1        Effective with Version H, the code indicating
```

Indicator Code   the presence of a demo trailer.

                                                      NOTE: During the Version H conversion this field
                                                      was populated throughout history (back to service
                                                      year 1991).

                                                      COBOL ALIAS: DEMO_IND
                                                      DB2 ALIAS: DEMO_TRLR_IND_CD
                                                      SAS ALIAS: DEMOIND
                                                      STANDARD ALIAS: NCH_DEMO_TRLR_IND_CD
                                                      TITLE ALIAS: DEMO_INDICATOR

                                                      CODES:
                                                      D = Demo trailer present

                                                      SOURCE:
                                                      NCH

181. Claim Demonstration   CHAR   2   Effective with Version H, the number assigned
     Identification Number   to identify a demo. This field is also used to
                                                      denote special processing (a.k.a. Special Processing
                                                      Number, SPN).

                                                      NOTE: Prior to Version H, Demo ID was stored in the
                                                      redefined Claim Edit Group, 4th occurrence, positions
                                                      3 and 4.   During the H conversion, this field was
                                                      populated with data throughout history (as appro-
                                                      priate either by moving ID on Version G or by
                                                      deriving from specific demo criteria).

                                                      01 = Nursing Home Case-Mix and Quality: NHCMQ
                                                           (RUGS) Demo -- testing PPS for SNFs in 6
                                                           states, using a case-mix classification
                                                           system based on resident characteristics and
                                                           actual resources used. The claims carry a
                                                           RUGS indicator and one or more revenue center
                                                           codes in the 9,000 series.

                                                      NOTE1: Effective for SNF claims with NCH weekly
                                                      process date after 2/8/96 (and service date after
                                                      12/31/95) -- beginning 4/97, Demo ID '01' was
                                                      derived in NCH based on presence of RUGS phase #
                                                      '2','3' or '4' on incoming claim; since 7/97, CWF
                                                      has been adding ID to claim.

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```
                                         POSITIONS
           NAME              TYPE  LENGTH BEG  END                          CONTENTS
------------------------     ----  ------ ---------   ------------------------------------------------------------
```

                                                        NOTE2: During the Version H conversion, Demo ID
                                                        '01' was populated back to NCH weekly process date
                                                        2/9/96 based on the RUGS phase indicator (stored
                                                        in Claim Edit Group, 3rd occurrence, 4th position,
                                                        in Version G).

                                                        02 = National HHA Prospective Payment Demo --
                                                             testing PPS for HHAs in 5 states, using two
                                                             alternate methods of paying HHAs: per visit
                                                             by type of HHA visit and per episode of HH
                                                             care.

                                                        NOTE1: Effective for HHA claims with NCH weekly
                                                        process date after 5/31/95 -- beginning 4/97,
                                                        Demo ID '02' was derived in NCH based on HCFA/
                                                        CHPP-supplied listing of provider # and start/
                                                        stop dates of participants.

                                                        NOTE2: During the Version H conversion, Demo ID
                                                        '02' was populated back to NCH weekly process
                                                        date 6/95 based on the CHPP criteria.

                                                        03 = Telemedicine Demo -- testing covering tradi-
                                                             tionally noncovered physician services for
                                                             medical consultation furnished via two-way, inter-
                                                             active video systems (i.e. teleconsultation)
                                                             in 4 states. The claims contain line items
                                                             with 'QQ' HCPCS code.

                                                        NOTE1: Effective for physician/supplier (nonDMERC)
                                                        claims with NCH weekly process date after 12/31/96
                                                        (and service date after 9/30/96) -- since 7/97,
                                                        CWF has been adding Demo ID '03' to claim.

                                                        NOTE2: During Version H conversion, Demo ID '03'
                                                        was populated back to NCH weekly process date 1/97
                                                        based on the presence of 'QQ' HCPCS on one or more

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                              inpatientsnf.txt
                       line items.

                       04 = United Mine Workers of America (UMWA) Managed
                            Care Demo -- testing risk sharing for Part A
                            services, paying special capitation rates for
                            all UMWA beneficiaries residing in 13 desig-
                            nated counties in 3 states.   Under the demo,
                            UMWA will waive the 3-day qualifying hospital
                            stay for a SNF admission.   The claims contain
                            TOB '18X','21X','28X' and '51X'; condition
                            code = W0; claim MCO paid switch = not '0';
                            and MCO contract # = '90091'.

                       NOTE:  Initially scheduled to be implemented for
                       all SNF claims for admission or services on
                       1/1/97 or later, CWF did not transmit any Demo
                       ID '04' annotated claims until on or about 2/98.
```

```
                                         POSITIONS
            NAME                 TYPE  LENGTH BEG  END                        CONTENTS
     ---------------------------  ----  ------ ---------  -------------------------------------------------------------
```

```
                       05 = Medicare Choices (MCO encounter data) demo --
                            testing expanding the type of Managed Care
                            plans available and different payment methods
                            at 16 MCOs in 9 states.   The claims contain
                            one of the specific MCO Plan Contract #
                            assigned to the Choices Demo site.

                       NOTE1:  Effective for all claim types with NCH
                       weekly process date after 7/31/97 -- CWF adds
                       Demo ID '05' to claim based on the presences of
                       the MCO Plan Contract #.

                       NOTE2:  During the Version H conversion, Demo ID
                       '05' was populated back to NCH weekly process
                       date 8/97 based on the presence of the Choices
                       indicator (stored as an alpha character cross-
                       walked from MCO plan contract # in the Claim
                       Edit Group, 4th occurrence, 2nd position, in
                       Version 'G').
```

```
                        inpatientsnf.txt
            06 = Coronary Artery Bypass Graft (CABG) Demo --
                 testing bundled payment (all-inclusive global
                 pricing) for hospital + physician services
                 related to CABG surgery in 7 hospitals in 7
                 states.  The inpatient claims contain a DRG
                 '106' or '107'.

            NOTE1:  Effective for Inpatient claims and
            physician/supplier claims with Claim Edit Date
            no earlier than 6/1/91 (not all CABG sites
            started at the same time) -- on 5/1/97, CWF
            started transmitting Demo ID '06' on the claim.
            The FI adds the ID to the claim based on the
            presence of DRG '106' or '107' from specific
            providers for specified time periods; the
            carrier adds the ID to the claim based on
            receiving 'Daily Census List' from parti-
            cipating hospitals.  Demo ID '06' will end
            once Demo ID '07' is implemented.

            NOTE2:  During the Version H conversion, any
            claims where Medicare is the primary payer
            that were not already  identified as Demo ID
            '06' (stored in the redefined Claim Edit
            Group, 4th occurrence, positions 3 and 4,
            Version G) were annotated based on the follow-
            ing criteria: Inpatient - presence of DRG '106'
            or '107' and a provider number=220897, 150897,
            380897,450897,110082,230156 or 360085 for
            specified service dates; noninstitutional -
            presence of HCPCS modifier (initial and/or
            second) = 'Q2' and a carrier number =00700/31143
            00630,01380,00900,01040/00511,00710,00623, or
            13630 for specified service dates.
```

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                                    POSITIONS
        NAME                 TYPE  LENGTH BEG  END                        CONTENTS
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                                               07 = Participating Centers of Excellence (PCOE)
                                                    Demo -- testing a negotiated all-inclusive
                                                    pricing arrangement (bundled rates) for high-
```

inpatientsnf.txt
cost acute care cardiovascular and orthopedic
procedures performed in 60-100 premier facili-
ties in the Chicago and San Francisco Regions
or by current CABG providers. The inpatient
claims will contain a DRG '104','105','106',
'107','112','124','125','209',or '471'; the
related physician/supplier claims will contain
the claim payment denial reason code = 'D'.

NOTE: The demo is on HOLD. The FI and carrier will
add Demo ID '07' to claim.

08 = Provider Partnership Demo -- testing per-case
     payment approaches for acute inpatient
     hospitalizations, making a lump-sum payment
     (combining the normal Part A PPS payment with
     the Part B allowed charges into a single fee
     schedule) to a Physician/Hospital Organization
     for all Part A and Part B services associated
     with a hospital admission. From 3 to 6 hospitals
     in the Northeast and Mid-Atlantic regions may
     participate in the demo.

NOTE: The demo is on HOLD. The FI and carrier will
add Demo ID '08' to claim.

15 = ESRD Managed Care (MCO encounter data) --
     testing open enrollment of ESRD beneficiaries
     and capitation rates adjusted for patient
     treatment needs at 3 MCOs in 3 States. The
     claims contain one of the specific MCO Plan
     Contract # assigned to the ESRD demo site.

NOTE: Effective 10/1/97 (but not actually imple-
mented at a site until 1/1/98) for all claim
types -- the FI and carrier add Demo ID '15' to
claim based on the presence of the MCO plan
contract #.

30 = Lung Volume Reduction Surgery (LVRS) or
     National Emphysema Treatment Trial (NETT)
     Clinical Study -- evaluating the effective-
     ness of LVRS and maximum medical therapy (in-
     cluding pulmonary rehab) for Medicare bene-

Page 111

ficiaries in last stages of emphysema at 18
hospitals nationally, in collaboration with
NIH.

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                              POSITIONS
        NAME               TYPE  LENGTH BEG  END                        CONTENTS
------------------------------ ---- ------ --------- ------------------------------------------------------------
```

                                                   NOTE: Effective for all claim types (except DMERC)
                                                   with NCH weekly process date after 2/27/98 (and
                                                   service date after 10/31/97) -- the FI adds Demo ID
                                                   '30' based on the presence of a condition code = EY;
                                                   the participating physician (not the carrier) adds
                                                   ID to the noninstitutional claim. DUE TO THE SEN-
                                                   SITIVE NATURE OF THIS CLINICAL TRIAL AND UNDER THE
                                                   TERMS OF THE INTERAGENCY AGREEMENT WITH NIH, THESE
                                                   CLAIMS ARE PROCESSED BY CWF AND TRANSMITTED TO
                                                   HCFA BUT NOT STORED IN THE NEARLINE FILE (access
                                                   is restricted to study evaluators only).

                                                   31 = VA Pricing Special Processing (SPN) -- not really
                                                        a demo but special request from VA due to
                                                        court settlement; not Medicare services but
                                                        VA inpatient and physician services submitted
                                                        to FI 00400 and Carrier 00900 to obtain
                                                        Medicare pricing -- CWF WILL PROCESS VA
                                                        CLAIMS ANNOTATED WITH DEMO ID '31', BUT WILL
                                                        NOT TRANSMIT TO HCFA (not in Nearline File).

                                                   37 = Medicare Coordinated Care Demonstration -- to test
                                                        whether coordinated care services furnished to
                                                        certain beneficiaries improve outcomes of care
                                                        and reduce Medicare expenditures under Part A and
                                                        Part B. There will be at least 9 Coordinated
                                                        Care Entities (CCEs). The selected entities will
                                                        be assigned a provider number specifically for the
                                                        demonstration services.

                                                   NOTE: The demo is on HOLD. The FI and carrier will
                                                   add Demo ID '37' to claim.

                                                   38 = Physician Encounter Claims - the purpose of this

inpatientsnf.txt
demo id is to identify the physician encounter
claims being processed at the HCFA Data Center (HDC).
This number will help EDS in making the claim go
through the appropriate processing logic, which
differs from that for fee-for-service. **NOT
IN NCH -- AVAILABLE IN NMUD.**

NOTE: Effective October, 2000. Demo ids will not be
assigned to Inpatient and Outpatient encounter claims.

39 = Centralized Billing of Flu and PPV Claims -- The
purpose of this demo is to facilitate the processing
carrier, Trailblazers, paying flu and PPV claims
based on payment localities. Providers will be
giving the shots throughout the country and trans-
mitting the claims to Trailblazers for processing.

NOTE: Effective October, 2000 for carrier claims.

| | | | POSITIONS | | |
NAME	TYPE	LENGTH	BEG	END	CONTENTS
					DB2 ALIAS: CLM_DEMO_ID_NUM
					SAS ALIAS: DEMONUM
					STANDARD ALIAS: CLM_DEMO_ID_NUM
					TITLE ALIAS: DEMO_ID
					SOURCE:
					CWF
182. Claim Demonstration Information Text	CHAR	15			Effective with Version H, the text field that contains related demo information. For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field.
					NOTE: During the Version H conversion this field was populated with data throughout history.

inpatientsnf.txt
DB2 ALIAS: CLM_DEMO_INFO_TXT
SAS ALIAS: DEMOTXT
STANDARD ALIAS: CLM_DEMO_INFO_TXT
TITLE ALIAS: DEMO_INFO

DERIVATION:
DERIVATION RULES:
Demo ID = 01 (RUGS) -- the text field will contain
a 2, 3 or 4 to denote the RUGS phase. If RUGS phase
is blank or not one of the above the text field
will reflect 'INVALID'. NOTE: In Version 'G', RUGS
phase was stored in redefined Claim Edit Group,
3rd occurrence, 4th position.

Demo ID = 02 (Home Health demo) -- the text field
will contain PROV#. When demo number not equal to
02 then text will reflect 'INVALID'.

Demo ID = 03 (Telemedicine demo) -- text field will
contain the HCPCS code. If the required HCPCS is
not shown then the text field will reflect
'INVALID'.

Demo ID = 04 (UMWA) -- text field will contain
W0 denoting that condition code W0 was present.
If condition code W0 not present then the text
field will reflect 'INVALID'.

Demo ID = 05 (CHOICES) -- the text field will con-
tain the CHOICES plan number, if both of the follow-
ing conditions are met: (1) CHOICES plan number
present and PPS or Inpatient claim shows that 1st
3 positions of provider number as '210' and the
admission date is within HMO effective/termination
date; or non-PPS claim and the from date is within

| | | | POSITIONS | | |
NAME	TYPE	LENGTH	BEG	END	CONTENTS

HMO effective/termination date and (2) CHOICES
plan number matches the HMO plan number. If
either condition is not met the text field will

inpatientsnf.txt
reflect 'INVALID CHOICES PLAN NUMBER'. When
CHOICES plan number not present, text will re-
flect 'INVALID'.

NOTE: In Version 'G', a valid CHOICES plan ID is
stored as alpha character in redefined Claim
Edit Group, 4th occurrence, 2nd position. If
invalid, CHOICES indicator 'ZZ' displayed.

Demo ID = 15 (ESRD Managed Care) -- text field
will contain the ESRD/MCO plan number. If ESRD/
MCO plan number not present the field will
reflect 'INVALID'.

Demo ID = 38 (Physician Encounter Claims) --
text field will contain the MCO plan number.
When MCO plan number not present the field will
reflect 'INVALID'.

SOURCE:
CWF

**** Claim Diagnosis Group   GROUP   7   The number of claim diagnosis trailers is
                                                       determined by the claim diagnosis code
                                                       count. The principal diagnosis is the first occurrence.
                                                       The 'E' code (ICD-9-CM code for the external cause
                                                       of an injury, poisoning, or adverse affect) is
                                                       stored as the last occurrence.
                                                       The principal diagnosis and the 'E' code are also
                                                       stored (redundantly) in the fixed portion
                                                       of the record.

                                                       NOTE:
                                                       Prior to Version H this group was named:
                                                       CLM_OTHR_DGNS_GRP and did not contain the
                                                       CLM_PRNCPAL_DGNS_CD.

                                                       OCCURS: UP TO 10 TIMES
                                                               DEPENDING ON IP_CLM_DGNS_CD_CNT

                                                       STANDARD ALIAS: CLM_DGNS_GRP

183. NCH Diagnosis Trailer   CHAR   1   Effective with Version H, the code indicating

Indicator Code

the presence of a diagnosis trailer.

NOTE: During the Version H conversion this field
was populated throughout history (back to service
year 1991).

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			POSITIONS		
NAME	TYPE	LENGTH	BEG	END	CONTENTS
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```
                                            DB2 ALIAS: DGNS_TRLR_IND_CD
                                            SAS ALIAS: DGNSIND
                                            STANDARD ALIAS: NCH_DGNS_TRLR_IND_CD

                                            CODES:
                                            Y = Diagnosis code trailer present

                                            SOURCE:
                                            NCH
```

184. Claim Diagnosis Code   CHAR   5   The ICD-9-CM based code identifying the
                                                     beneficiary's principal or other diagnosis
                                                     (including E code).

                                                     NOTE:
                                                     Prior to Version H, the principal diagnosis
                                                     code was not stored with the 'OTHER' diagnosis
                                                     codes. During the Version H conversion the
                                                     CLM_PRNCPAL_DGNS_CD was added as the first
                                                     occurrence.

                                                     DB2 ALIAS: CLM_DGNS_CD
                                                     SAS ALIAS: DGNS_CD
                                                     STANDARD ALIAS: CLM_DGNS_CD
                                                     TITLE ALIAS: DIAGNOSIS

                                                     EDIT-RULES:
                                                     ICD-9-CM

                                                     COMMENT:
                                                     Prior to Version H this field was named:
                                                     CLM_OTHR_DGNS_CD.

```
185. FILLER                        CHAR      1

**** Claim Procedure Group         GROUP     16            The number of claim procedure trailers is determined
                                                           by the claim procedure code count.  Prior to 10/93
                                                           up to 10 occurrences could be reported on an
                                                           institutional claim.  Beginning 10/93, up to six
                                                           occurrences (one principal; five others) may be
                                                           reported.

                                                           OCCURS: UP TO 6 TIMES
                                                                   DEPENDING ON IP_CLM_PRCDR_CD_CNT

                                                           STANDARD ALIAS: CLM_PRCDR_GRP

186. NCH Procedure Trailer         CHAR      1             Effective with Version H, the code indicating the presence
     Indicator Code                                        of a procedure trailer.

                                                           NOTE:  During the Version H conversion this field was
                                                           populated throughout history (back to service year 1991).
```

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```
                                        POSITIONS
            NAME                   TYPE  LENGTH BEG  END                         CONTENTS
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                                                           DB2 ALIAS: PRCDR_TRLR_IND_CD
                                                           SAS ALIAS: PRCDRIND
                                                           STANDARD ALIAS: NCH_PRCDR_TRLR_IND_CD

                                                           CODES:
                                                           Z = Procedure code trailer present

                                                           SOURCE:
                                                           NCH

187. Claim Procedure Code          CHAR      4             The ICD-9-CM code that indicates the principal or other
                                                           procedure performed during the period covered by the
                                                           institutional claim.

                                                           DB2 ALIAS: CLM_PRCDR_CD
                                                           SAS ALIAS: PRCDR_CD
                                                           STANDARD ALIAS: CLM_PRCDR_CD
```

```
                            inpatientsnf.txt
                            TITLE ALIAS: PROCEDURE_CODE

                            EDIT-RULES:
                            ICD-9-CM

                            SOURCE:
                            CWF

   188.  FILLER                       CHAR      3

   189.  Claim Procedure Performed    NUM       8       On an institutional claim, the date on which
         Date                                           the principal or other procedure was performed.

                                                        8 DIGITS UNSIGNED

                                                        DB2 ALIAS: CLM_PRCDR_PRFRM_DT
                                                        SAS ALIAS: PRCDR_DT
                                                        STANDARD ALIAS: CLM_PRCDR_PRFRM_DT
                                                        TITLE ALIAS: PROCEDURE_DATE

                                                        EDIT-RULES:
                                                        YYYYMMDD

                                                        SOURCE:
                                                        CWF

 ****   Claim Related Condition       GROUP     3       The number of claim related condition trailers is
        Group                                           determined by the claim related condition code count.
                                                        Effective 10/93, up to 30 occurrences can be reported
                                                        on an institutional claim.  Prior to 10/93, up to
                                                        10 occurrences could be reported.

                                                        OCCURS: UP TO 30 TIMES
                                                                DEPENDING ON IP_CLM_RLT_COND_CD_CNT

                                                        STANDARD ALIAS: CLM_RLT_COND_GRP
```

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```
                                     POSITIONS
             NAME               TYPE  LENGTH BEG  END                       CONTENTS
   ---------------------------- ----  ------ ---------  ----------------------------------------------------------

   190.  NCH Condition Trailer        CHAR      1       Effective with Version H, the code indicating
```

Indicator Code

the presence of a condition code trailer.

NOTE: During the Version H conversion this field
was populated throughout history (back to service
year 1991).

DB2 ALIAS: COND_TRLR_IND_CD
SAS ALIAS: CONDIND
STANDARD ALIAS: NCH_COND_TRLR_IND_CD

CODES:
C = Condition code trailer present

SOURCE:
NCH

191. Claim Related Condition   CHAR   2
     Code

The code that indicates a condition relating to
an institutional claim that may affect payer
processing.

DB2 ALIAS: CLM_RLT_COND_CD
SAS ALIAS: RLT_COND
STANDARD ALIAS: CLM_RLT_COND_CD
SYSTEM ALIAS: LTCOND
TITLE ALIAS: RELATED_CONDITION_CD

CODES:
01 THRU 16 = Insurance related
17 THRU 30 = Special condition
31 THRU 35 = Student status codes which are required
             when a patient is a dependent child
             over 18 years old
36 THRU 45 = Accommodation
46 THRU 54 = CHAMPUS information
55 THRU 59 = Skilled nursing facility
60 THRU 70 = Prospective payment
71 THRU 99 = Renal dialysis setting
A0 THRU B9 = Special program codes
C0 THRU C9 = PRO approval services
D0 THRU W0 = Change conditions

CODES:
  REFER TO: CLM_RLT_COND_TB
            IN THE CODES APPENDIX

```
                                        SOURCE:
                                        CWF

****  Claim Related Occurrence    GROUP    11        The number of claim related occurrence trailers is
      Group                                          determined by the claim related occurrence code count.
                                                     Effective 10/93, up to 30 occurrences can be reported
                                                     on an institutional claim.  Prior to 10/93, up to 10
                                                     occurrences could be reported.
1                      FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                       POSITIONS
              NAME            TYPE  LENGTH BEG  END                          CONTENTS
      ----------------------- ----  ------ ---------  --------------------------------------------------------

                                                     OCCURS: UP TO 30 TIMES
                                                             DEPENDING ON IP_CLM_RLT_OCRNC_CD_CNT

                                                     STANDARD ALIAS: CLM_RLT_OCRNC_GRP

192.  NCH Occurrence Trailer  CHAR     1             Effective with Version H, the code indicating
      Indicator Code                                 the presence of a occurrence code trailer.

                                                     NOTE:  During the Version H conversion this field
                                                     was populated throughout history (back to service
                                                     year 1991).

                                                     DB2 ALIAS: OCRNC_TRLR_IND_CD
                                                     SAS ALIAS: OCRNCIND
                                                     STANDARD ALIAS: NCH_OCRNC_TRLR_IND_CD

                                                     CODES:
                                                     O = Occurrence code trailer present

                                                     SOURCE:
                                                     NCH

193.  Claim Related Occurrence CHAR    2             The code that identifies a significant event
      Code                                           relating to an institutional claim that may
                                                     affect payer processing.  These codes are
                                                     claim-related occurrences that are related
                                                     to a specific date.

                                                     DB2 ALIAS: CLM_RLT_OCRNC_CD
```

```
                            SAS ALIAS: OCRNC_CD
                            STANDARD ALIAS: CLM_RLT_OCRNC_CD
                            SYSTEM ALIAS: LTOCRNC
                            TITLE ALIAS: OCCURRENCE_CD

                            CODES:
                            01 THRU 09 = Accident
                            10 THRU 19 = Medical condition
                            20 THRU 39 = Insurance related
                            40 THRU 69 = Service related
                            A1-A3 = Miscellaneous

                            CODES:
                              REFER TO: CLM_RLT_OCRNC_TB
                                        IN THE CODES APPENDIX

                            SOURCE:
                            CWF
```

194. Claim Related Occurrence   NUM   8   The date associated with a significant event
     Date   related to an institutional claim that may
                                                       affect payer processing.

                                                       8 DIGITS UNSIGNED

```
                                     POSITIONS
            NAME            TYPE  LENGTH BEG  END                              CONTENTS
    ---------------------------  ----  ------ ---------  ----------------------------------------------------------
                            DB2 ALIAS: CLM_RLT_OCRNC_DT
                            SAS ALIAS: OCRNCDT
                            STANDARD ALIAS: CLM_RLT_OCRNC_DT
                            TITLE ALIAS: RLT_OCRNC_DT

                            EDIT-RULES:
                            YYYYMMDD

                            SOURCE:
                            CWF
```

 **** Claim Occurrence Span Group GROUP   19   The number of claim occurrence span trailers is
                                                         determined by the claim occurrence span code count.

Up to 10 occurrences may be reported on an
institutional claim.

OCCURS: UP TO 10 TIMES
        DEPENDING ON IP_CLM_OCRNC_SPAN_CD_CNT

STANDARD ALIAS: CLM_OCRNC_SPAN_GRP

195. NCH Span Trailer Indicator   CHAR   1   Effective with Version H, the code indicating
     Code   the presence of a span code trailer.

                                                       NOTE: During the Version H conversion this field
                                                       was populated throughout history (back to service
                                                       year 1991).

                                                       DB2 ALIAS: SPAN_TRLR_IND_CD
                                                       SAS ALIAS: SPANIND
                                                       STANDARD ALIAS: NCH_SPAN_TRLR_IND_CD

                                                       CODES:
                                                       S = Span code trailer present

                                                       SOURCE:
                                                       NCH

196. Claim Occurrence Span Code   CHAR   2   The code that identifies a significant event
                                                       relating to an institutional claim that may
                                                       affect payer processing. These codes are
                                                       claim-related occurrences that are related
                                                       to a time period (span of dates).

                                                       DB2 ALIAS: CLM_OCRNC_SPAN_CD
                                                       SAS ALIAS: SPAN_CD
                                                       STANDARD ALIAS: CLM_OCRNC_SPAN_CD
                                                       SYSTEM ALIAS: LTSPAN
                                                       TITLE ALIAS: SPAN_CD

                                                       CODES:
                                                         REFER TO: CLM_OCRNC_SPAN_TB
                                                                 IN THE CODES APPENDIX

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                                   POSITIONS

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                  NAME                TYPE  LENGTH BEG   END                                    CONTENTS
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```

			SOURCE: CWF
197. Claim Occurrence Span From Date	NUM	8	The from date of a period associated with an occurrence of a specific event relating to an institutional claim that may affect payer processing. 8 DIGITS UNSIGNED DB2 ALIAS: OCRNC_SPAN_FROM_DT SAS ALIAS: SPANFROM STANDARD ALIAS: CLM_OCRNC_SPAN_FROM_DT TITLE ALIAS: SPAN_FROM_DT EDIT-RULES: YYYYMMDD SOURCE: CWF
198. Claim Occurrence Span Through Date	NUM	8	The thru date of a period associated with an occurrence of a specific event relating to an institutional claim that may affect payer processing. 8 DIGITS UNSIGNED DB2 ALIAS: OCRNC_SPAN_THRU_DT SAS ALIAS: SPANTHRU STANDARD ALIAS: CLM_OCRNC_SPAN_THRU_DT TITLE ALIAS: SPAN_THRU_DT EDIT-RULES: YYYYMMDD SOURCE: CWF
**** Claim Value Group	GROUP	9	The number of claim value data trailers present is determined by the claim value code count. Effective

inpatientsnf.txt
                         10/93, up to 36 occurrences can be reported on an
                         institutional claim. Prior to 10/93, up to 10
                         occurrences could be reported.

                         OCCURS: UP TO 36 TIMES
                              DEPENDING ON IP_CLM_VAL_CD_CNT

                         STANDARD ALIAS: CLM_VAL_GRP

  199. NCH Value Trailer Indicator CHAR   1   Effective with Version H, the code indicating
       Code   the presence of a value code trailer.

                                        POSITIONS
              NAME   TYPE LENGTH BEG END   CONTENTS
     ---------------------------- ---- ------ --------- --

                                                          NOTE: During the Version H conversion this field
                                                          was populated throughout history (back to service
                                                          year 1991).

                                                          DB2 ALIAS: VAL_TRLR_IND_CD
                                                          SAS ALIAS: VALIND
                                                          STANDARD ALIAS: NCH_VAL_TRLR_IND_CD

                                                          CODES:
                                                          V = Value code trailer present

                                                          SOURCE:
                                                          NCH

  200. Claim Value Code   CHAR   2   The code indicating the value of a monetary
                                                        condition which was used by the intermediary
                                                        to process an institutional claim.

                                                        DB2 ALIAS: CLM_VAL_CD
                                                        SAS ALIAS: VAL_CD
                                                        STANDARD ALIAS: CLM_VAL_CD
                                                        SYSTEM ALIAS: LTVALUE
                                                        TITLE ALIAS: VALUE_CD

                                                        CODES:
                                                          REFER TO: CLM_VAL_TB

                                   Page 124

                                    IN THE CODES APPENDIX

                                    SOURCE:
                                    CWF

 201. Claim Value Amount   PACK   6   The amount related to the condition identified
                                                      in the CLM_VAL_CD which was used by the
                                                      intermediary to process the institutional
                                                      claim.

                                                      9.2 DIGITS SIGNED

                                                      DB2 ALIAS: CLM_VAL_AMT
                                                      SAS ALIAS: VAL_AMT
                                                      STANDARD ALIAS: CLM_VAL_AMT
                                                      TITLE ALIAS: VALUE_AMOUNT

                                                      EDIT-RULES:
                                                      $$$$$$$$$CC

                                                      SOURCE:
                                                      CWF

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                                          POSITIONS
              NAME   TYPE   LENGTH BEG   END   CONTENTS
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 **** Claim Revenue Center Group   GROUP   224   The number of claim revenue center data trailers is
                                                          determined by the claim revenue center code count.
                                                          Effective 7/7/00, up to 450 occurrences may be reported
                                                          for an institutional claim. The increase in the
                                                          number of revenue center lines causes each claim to
                                                          be broken out into records/segments (up to 10). Each
                                                          record can have up to 45 occurrences of revenue center
                                                          lines. Prior to 7/7/00, up to 58 occurrences may be
                                                          reported on an institutional claim. Claims submitted
                                                          prior to 10/93, contained up to 28 occurrences.

                                                          OCCURS: UP TO 45 TIMES
                                                                 DEPENDING ON IP_REV_CNTR_CD_I_CNT

                                    Page 125

```
                    inpatientsnf.txt
          STANDARD ALIAS: CLM_REV_CNTR_GRP

          COMMENT:
          ****************** FOR SNF PPS *********************
          The Balanced Budget Act modified how payment will be
          made for skilled nursing facility (SNF) services.
          Effective with cost reporting periods beginning on or
          after 7/1/98 (with all providers transitioning by
          6/30/99, SNFs will be paid on a prospective payment
          system (PPS).

          SNFs will classify beneficiaries on the basis of
          residents' characteristics and resource needs, using
          the 44-group patient classification system known as
          Resource Utilization Groups (RUGS), Version III.
          Facilities will use information from the Minimum Data
          Set (MDS), Version 2.0, Resident Assessment Instrument
          (RAI) to classify residents into the RUG-III groups.

          ***************** FOR OUTPATIENT PPS ***************
          The Balanced Budget Act modified how payment will be
          made for hospital outpatient services, certain PTB
          services furnished to inpatients who have no PTA
          coverage, CMHCs, and limited services provided by
          CORFs, Home Health Agencies or to hospice patients
          for the treatment of a non-terminal illness.  Imple-
          mentation for Outpatient PPS (OPPS) will be effective
          for claims with dates of service on or after
          July 1, 2000.

          Payment for services under the OPPS system is
          calculated based on grouping outpatient services
          into ambulatory payment classifications (APC) groups.

          *************** FOR HOME HEALTH PPS ***************
          The Balanced Budget Act of 1997 mandated changes in
          payment and other provider requirements for home
          health.  All home health agencies will be paid
          through a prospective payment system beginning
          October 1, 2000.
```

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                              POSITIONS
NAME                  TYPE  LENGTH BEG  END                           CONTENTS
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-------------------------- ---- ------ --------- -----------------------------------------------------------
```

Under Home Health PPS (HH PPS) the unit of payment will be a 60-day episode. Home Health Resources Groups (HHRGs), also called HRGs represented by HCFA HIPPS coding, will be the basis of payment for each episode; HHRGs will be produced through pubicly available Grouper software that will determine the appropriate HHRG when results of comprehensive assessments of the beneficiary (made incorporating the OASIS data set) are input or grouped in this software.

202. NCH Revenue Center Trailer   CHAR   1   Effective with Version H, the code identifying the
     Indicator Code   revenue center trailer.

                                                        During the Version H conversion this field was
                                                        populated with data throughout history (back to
                                                        service year 1991).

                                                        DB2 ALIAS: REV_CNTR_TRLR_CD
                                                        SAS ALIAS: REVIND
                                                        STANDARD ALIAS: NCH_REV_CNTR_TRLR_IND_CD

                                                        CODES:
                                                        R = Revenue code trailer present

                                                        SOURCE:
                                                        NCH

203. Revenue Center Code   CHAR   4   The provider-assigned revenue code for each cost center for
                                                        which a separate charge is billed (type of accommodation or
                                                        ancillary). A cost center is a division or unit within a
                                                        hospital (e.g., radiology, emergency room, pathology).
                                                        EXCEPTION: Revenue center code 0001 represents the total of
                                                        all revenue centers included on the claim.

                                                        COBOL ALIAS: REV_CD
                                                        DB2 ALIAS: REV_CNTR_CD
                                                        SAS ALIAS: REV_CNTR
                                                        STANDARD ALIAS: REV_CNTR_CD
                                                        SYSTEM ALIAS: LTRC
                                                        TITLE ALIAS: REVENUE_CENTER_CD

                           CODES:
                             REFER TO: REV_CNTR_TB
                                       IN THE CODES APPENDIX

                           SOURCE:
                           CWF

  204. Revenue Center Date   NUM   8   Effective with Version H, the date applicable
                                                         to the service represented by the revenue center
                                                         code.   This field may be present on any of the
                                                         institutional claim types. For home health claims
                                                         the service date should be present on all bills
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                                            POSITIONS
                NAME   TYPE LENGTH BEG END   CONTENTS
         --------------------------- ---- ------ --------- --

                                                         with from date greater than 3/31/98. With the
                                                         implementation of outpatient PPS, hospitals will
                                                         be required to enter line item dates of service
                                                         for all outpatient services which require a HCPCS.

                                                         NOTE1: Beginning with NCH weekly process date
                                                         10/3/97 this field was populated with data.
                                                         Claims processed prior to 10/3/97 will contain
                                                         zeroes in this field.

                                                         NOTE2: When revenue center code equals '0022'
                                                         (SNF PPS) and revenue center HCPCS code not equal
                                                         to 'AAA00' (default for no assessment), date re-
                                                         presents the MDS RAI assessment reference date.

                                                         NOTE3: When revenue center code equals '0023'
                                                         (HHPPS), the date on the initial claim (RAP) must
                                                         represent the first date of service in the episode.
                                                         The final claim will match the '0023' information
                                                         submitted on the initial claim. The SCIC
                                                         (significant change in condition) claims may show
                                                         additional '0023' revenue lines in which the
                                                         date represents the date of the first service
                                                         under the revised plan of treatment.

                                                         8 DIGITS UNSIGNED

```
                                DB2 ALIAS: REV_CNTR_DT
                                SAS ALIAS: REV_DT
                                STANDARD ALIAS: REV_CNTR_DT
                                TITLE ALIAS: REV_CNTR_DATE

                                EDIT-RULES:
                                YYYYMMDD

                                SOURCE:
                                CWF
```

205. Revenue Center 1st ANSI   CHAR   5   The first code used to identify the
     Code   detailed reason an adjustment was made
                                                (e.g. reason for denial or reducing payment).

                                                NOTE: Beginning with NCH weekly process date
                                                7/7/00, this field will be populated with data.
                                                Claims processed prior to 7/7/00 will contain
                                                spaces in this field.

```
                                DB2 ALIAS: REV_CNTR_ANSI1_CD
                                SAS ALIAS: REVANSI1
                                STANDARD ALIAS: REV_CNTR_ANSI_1_CD
                                SYSTEM ALIAS: LTANSI
                                TITLE ALIAS: ANSI_CD
```

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| | | | POSITIONS | | |
NAME	TYPE	LENGTH	BEG	END		CONTENTS

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                                CODES:
                                  REFER TO: REV_CNTR_ANSI_TB
                                         IN THE CODES APPENDIX

                                SOURCE:
                                CWF
```

206. Revenue Center 2nd ANSI   CHAR   5   The second code used to identify the
     Code   detailed reason an adjustment was made
                                                (e.g. reason for denial or reducing payment).

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NOTE: Beginning with NCH weekly process date
7/7/00, this field will be populated with data.
Claims processed prior to 7/7/00 will contain
spaces in this field.

DB2 ALIAS: REV_CNTR_ANSI2_CD
SAS ALIAS: REVANSI2
STANDARD ALIAS: REV_CNTR_ANSI_2_CD
TITLE ALIAS: ANSI_CD

SOURCE:
CWF

207. Revenue Center 3rd ANSI   CHAR   5   The third code used to identify the
     Code   detailed reason an adjustment was made
                                                     (e.g. reason for denial or reducing payment).

                                                     NOTE: Beginning with NCH weekly process date
                                                     7/7/00, this field will be populated with data.
                                                     Claims processed prior to 7/7/00 will contain
                                                     spaces in this field.

                                                     DB2 ALIAS: REV_CNTR_ANSI3_CD
                                                     SAS ALIAS: REVANSI3
                                                     STANDARD ALIAS: REV_CNTR_ANSI_3_CD
                                                     TITLE ALIAS: ANSI_CD

                                                     SOURCE:
                                                     CWF

208. Revenue Center 4th ANSI   CHAR   5   The fourth code used to identify the
     Code   detailed reason an adjustment was made
                                                     (e.g. reason for denial or reducing payment).

                                                     NOTE: Beginning with NCH weekly process date
                                                     7/7/00, this field will be populated with data.
                                                     Claims processed prior to 7/7/00 will contain
                                                     spaces in this field.

                                                     DB2 ALIAS: REV_CNTR_ANSI4_CD
                                                     SAS ALIAS: REVANSI4
                                                     STANDARD ALIAS: REV_CNTR_ANSI_4_CD
                                                     TITLE ALIAS: ANSI_CD

```
                                      POSITIONS
              NAME              TYPE  LENGTH BEG  END                      CONTENTS
     ----------------------------  ----  ------ ---------   ------------------------------------------------------------
                                                            SOURCE:
                                                            CWF

     209. Revenue Center APC/HIPPS  CHAR     5              Effective with Outpatient PPS (OPPS), the Ambulatory
          Code                                             Payment Classification (APC) code used to identify
                                                            groupings of outpatient services.  APC codes are
                                                            used to calculate payment for services under
                                                            OPPS.

                                                            Effective with Home Health PPS (HHPPS), this field
                                                            will only be populated with a HIPPS code if the HIPPS
                                                            code that is stored in the HCPCS field has been
                                                            downcoded and the new code will be placed in this
                                                            field.

                                                            NOTE1: Under SNF PPS and HHPPS, HIPPS codes are
                                                            stored in the HCPCS field. **EXCEPTION: if a
                                                            HHPPS HIPPS code is downcoded the downcoded
                                                            HIPPS will be stored in this field.

                                                            NOTE2:  Beginning with NCH weekly process date
                                                            8/18/00, this field will be populated with data.
                                                            Claims processed prior to 8/18/00 will contain
                                                            spaces in this field.

                                                            DB2 ALIAS: REV_APC_HIPPS_CD
                                                            SAS ALIAS: APCHIPPS
                                                            STANDARD ALIAS: REV_CNTR_APC_HIPPS_CD
                                                            SYSTEM ALIAS: LTAPC
                                                            TITLE ALIAS: APC_HIPPS

                                                            CODES:
                                                              REFER TO: REV_CNTR_APC_TB
                                                                        IN THE CODES APPENDIX

                                                            SOURCE:
                                                            CWF
```

210. Revenue Center HCFA Common   CHAR   5   HCFA's Common Procedure Coding System (HCPCS)
     Procedure Coding System   is a collection of codes that represent procedures,
     Code   supplies, products and services which may be
                                                            provided to Medicare beneficiaries and to
                                                            individuals enrolled in private health
                                                            insurance programs. The codes are divided
                                                            into three levels, or groups, as described
                                                            below:

                                                            DB2 ALIAS: REV_CNTR_HCPCS_CD
                                                            SAS ALIAS: HCPCS_CD
                                                            STANDARD ALIAS: REV_CNTR_HCPCS_CD
                                                            SYSTEM ALIAS: LTHIPPS
                                                            TITLE ALIAS: HCPCS_CD

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                                          POSITIONS
                NAME   TYPE LENGTH BEG END   CONTENTS
     ---------------------------   ---- ------ ---------   --

                                                            CODES:
                                                              REFER TO: CLM_HIPPS_TB
                                                                        IN THE CODES APPENDIX

                                                            COMMENT:
                                                            Prior to Version H this field was named:
                                                            HCPCS_CD. With Version H, a prefix
                                                            was added to denote the location of this field
                                                            on each claim type (institutional: REV_CNTR and
                                                            non-institutional: LINE).

                                                            NOTE: When revenue center code = '0022' (SNF PPS)
                                                            or '0023' (HH PPS), this field contains the Health
                                                            Insurance PPS (HIPPS) code. The HIPPS code for
                                                            SNF PPS contains the rate code/assessment type that
                                                            identifies (1) RUG-III group the beneficiary was
                                                            classified into as of the RAI MDS assessment reference
                                                            date and (2) the type of assessment for payment pur-
                                                            poses.

                                                            The HIPPS code for Home Health PPS identifies
                                                            (1) the three case-mix dimensions of the HHRG system,
                                                            clinical, functional and utilization, from which a

                                        Page 132

beneficiary is assigned to one of the 80 HHRG
categories and (2) it identifies whether or not
the elements of the code were computed or derived.
The HHRGs, represented by the HIPPS coding, will be
the basis of payment for each episode.

For both SNF PPS & HH PPS HIPPS values see CLM_HIPPS_TB.

Level I
    Codes and descriptors copyrighted by the American
    Medical Association's Current Procedural
    Terminology, Fourth Edition (CPT-4). These are
    5 position numeric codes representing physician
    and nonphysician services.

    **** Note: ****
    CPT-4 codes including both long and short
    descriptions shall be used in accordance with the
    HCFA/AMA agreement. Any other use violates the
    AMA copyright.

Level II
    Includes codes and descriptors copyrighted by
    the American Dental Association's Current Dental
    Terminology, Second Edition (CDT-2). These are
    5 position alpha-numeric codes comprising
    the D series. All other level II codes and
    descriptors are approved and maintained jointly
    by the alpha-numeric editorial panel (consisting
    of HCFA, the Health Insurance Association of
    America, and the Blue Cross and Blue Shield
    Association). These are 5 position alpha-

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                                    POSITIONS
          NAME              TYPE  LENGTH BEG   END                              CONTENTS
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                                                      numeric codes representing primarily items and
                                                      nonphysician services that are not
                                                      represented in the level I codes.

                                                Level III
                                                    Codes and descriptors developed by Medicare

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carriers for use at the local (carrier) level.
These are 5 position alpha-numeric codes in the
W, X, Y or Z series representing physician
and nonphysician services that are not
represented in the level I or level II codes.

211. Revenue Center HCPCS   CHAR   2   A first modifier to the procedure code to enable a more
     Initial Modifier Code   specific procedure identification for the claim.

                                                         DB2 ALIAS: REV_HCPCS_MDFR_CD
                                                         SAS ALIAS: MDFR_CD1
                                                         STANDARD ALIAS: REV_CNTR_HCPCS_INITL_MDFR_CD
                                                         TITLE ALIAS: INITIAL_MODIFIER

                                                         EDIT-RULES:
                                                         Carrier Information File

                                                         COMMENT:
                                                         Prior to Version H this field was named:
                                                         HCPCS_INITL_MDFR_CD. With Version H, a prefix
                                                         was added to denote the location of this field
                                                         on each claim type (institutional: REV_CNTR and
                                                         non-institutional: LINE).

                                                         SOURCE:
                                                         CWF

212. Revenue Center HCPCS Second CHAR   2   A second modifier to the procedure code to make it more
     Modifier Code   specific than the first modifier code to identify the
                                                         procedures performed on the beneficiary for the claim.

                                                         DB2 ALIAS: REV_HCPCS_2ND_CD
                                                         SAS ALIAS: MDFR_CD2
                                                         STANDARD ALIAS: REV_CNTR_HCPCS_2ND_MDFR_CD
                                                         TITLE ALIAS: SECOND_MODIFIER

                                                         EDIT-RULES:
                                                         CARRIER INFORMATION FILE

                                                         COMMENT:
                                                         Prior to Version H this field was named:
                                                         HCPCS_2ND_MDFR_CD. With Version H, a prefix
                                                         was added to denote the location of this field
                                                         on each claim type (institutional: REV_CNTR and

                      SOURCE:
                      CWF

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                                      POSITIONS
              NAME              TYPE  LENGTH BEG  END                        CONTENTS
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213. Revenue Center HCPCS Third   CHAR   2   Effective with Version I, a third modifier to the
     Modifier Code   procedure code to make it more specific than the
                                                             second modifier code to identify the procedures
                                                             performed on the beneficiary for the claim.

                                                             DB2 ALIAS: REV_HCPCS_3RD_CD
                                                             SAS ALIAS: MDFR_CD3
                                                             STANDARD ALIAS: REV_CNTR_HCPCS_3RD_MDFR_CD
                                                             TITLE ALIAS: THIRD_MODIFIER

                                                             EDIT-RULES:
                                                             CARRIER INFORMATION FILE

                                                             COMMENT:
                                                             NOTE: Beginning with NCH weekly process date
                                                             8/18/00, this field will be populated with data.
                                                             Claims processed prior to 8/18/00 will contain
                                                             spaces in this field.

                                                             SOURCE:
                                                             CWF

214. Revenue Center HCPCS Fourth CHAR   2   Effective with Version I, a fourth modifier to the
     Modifier Code   procedure code to make it more specific than the
                                                             third modifier code to identify the procedures
                                                             performed on the beneficiary for the claim.

                                                             DB2 ALIAS: REV_HCPCS_4TH_CD
                                                             SAS ALIAS: MDFR_CD4
                                                             STANDARD ALIAS: REV_CNTR_HCPCS_4TH_MDFR_CD
                                                             TITLE ALIAS: FOURTH_MODIFIER

                                                             EDIT-RULES:

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                           inpatientsnf.txt
                    CARRIER INFORMATION FILE

                    COMMENT:
                    NOTE:  Beginning with NCH weekly process date
                    8/18/00, this field will be populated with data.
                    Claims processed prior to 8/18/00 will contain
                    spaces in this field.

                    SOURCE:
                    CWF

215. Revenue Center HCPCS Fifth    CHAR      2         Effective with Version I, a fifth modifier to the
     Modifier Code                                     procedure code to make it more specific than the
                                                       fourth modifier code to identify the procedures
                                                       performed on the beneficiary for the claim.

                    DB2 ALIAS: REV_HCPCS_5TH_CD
                    SAS ALIAS: MDFR_CD5
                    STANDARD ALIAS: REV_CNTR_HCPCS_5TH_MDFR_CD
                    TITLE ALIAS: FIFTH_MODIFIER
```

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                                   POSITIONS
         NAME                 TYPE  LENGTH BEG   END                            CONTENTS
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                    EDIT-RULES:
                    CARRIER INFORMATION FILE

                    COMMENT:
                    NOTE:  Beginning with NCH weekly process date
                    8/18/00, this field will be populated with data.
                    Claims processed prior to 8/18/00 will contain
                    spaces in this field.

                    SOURCE:
                    CWF

216. Revenue Center Payment        CHAR      2         Effective with Version 'I', the code used to
     Method Indicator Code                             identify how the service is priced for payment.
                                                       This field is made up of two pieces of data,
                                                       1st position being the service indicator and
                                                       the 2nd position being the payment indicator.
```

NOTE: Beginning with NCH weekly process date
8/18/00, this field will be populated with data.
Claims processed prior to 8/18/00 will contain
spaces in this field.

DB2 ALIAS: REV_PMT_MTHD_CD
SAS ALIAS: PMTMTHD
STANDARD ALIAS: REV_CNTR_PMT_MTHD_IND_CD
SYSTEM ALIAS: LTPMTHD
TITLE ALIAS: PMT_MTHD

CODES:
   REFER TO: REV_CNTR_PMT_MTHD_IND_TB
             IN THE CODES APPENDIX

SOURCE:
CWF

217. Revenue Center Discount   CHAR   1   Effective with Version 'I', for all services
     Indicator Code   subject to Outpatient PPS, this code represents
                                                        a factor that specifies the amount of any APC
                                                        discount. The discounting factor is applied
                                                        to a line item with a service indicator (part
                                                        of the REV_CNTR_PMT_MTHD_IND_CD) of 'T'. The
                                                        flag is applicable when more than one significant
                                                        procedure is performed. **If there is no dis-
                                                        counting the factor will be 1.0.**

                                                        NOTE1: Beginning with NCH weekly process date
                                                        8/18/00, this field will be populated with data.
                                                        Claims processed prior to 8/18/00 will contain
                                                        spaces in this field.

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                              POSITIONS
              NAME   TYPE LENGTH BEG END   CONTENTS
     ------------------------------ ---- ------ --------- --

                                                        DB2 ALIAS: REV_DSCNT_IND_CD
                                                        SAS ALIAS: DSCNTIND
                                                        STANDARD ALIAS: REV_CNTR_DSCNT_IND_CD
                                                        SYSTEM ALIAS: LTDSCNT

inpatientsnf.txt
TITLE ALIAS: REV_CNTR_DSCNT_IND_CD

CODES:
DISCOUNTING FORMULAS
1 = 1.0
2 = (1.0+D(U-1))/U
3 = T/U
4 = (1+D)/U
5 = D
6 = TD/U
7 = D(1+D)/U
8 = 2.0/U

SOURCE:
CWF

218. Revenue Center Packaging   CHAR   1   Effective with Version 'I', for all services
     Indicator Code   subject to Outpatient PPS, the code used to
                                                        identify those services that are packaged/
                                                        bundled with another service.

                                                        NOTE: Beginning with NCH weekly process date
                                                        8/18/00, this field will be populated with data.
                                                        Claims processed prior to 8/18/00 will contain
                                                        spaces in this field.

                                                        DB2 ALIAS: REV_PACKG_IND_CD
                                                        SAS ALIAS: PACKGIND
                                                        STANDARD ALIAS: REV_CNTR_PACKG_IND_CD
                                                        SYSTEM ALIAS: LTPACKG
                                                        TITLE ALIAS: REV_CNTR_PACKG_IND

                                                        CODES:
                                                        0 = Not packaged
                                                        1 = Packaged service (service indicator N)
                                                        2 = Packaged as part of partial hospitalization
                                                            per diem or daily mental health service
                                                            per diem

                                                        SOURCE:
                                                        CWF

219. Revenue Center Pricing   CHAR   2   Effective with Version 'I', the code used
     Indicator Code   to identify if there was a deviation from

the standard method of calculating payment
amount.

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                        POSITIONS
              NAME              TYPE  LENGTH BEG   END                                CONTENTS
     ----------------------------  ----  ------ ---------  ------------------------------------------------------------
```

                                                         NOTE: Beginning with NCH weekly process date
                                                         8/18/00, this field will be populated with data.
                                                         Claims processed prior to 8/18/00 will contain
                                                         spaces in this field.

                                                         DB2 ALIAS: REV_PRICNG_IND_CD
                                                         SAS ALIAS: PRICNG
                                                         STANDARD ALIAS: REV_CNTR_PRICNG_IND_CD
                                                         SYSTEM ALIAS: LTPRICNG
                                                         TITLE ALIAS: REV_CNTR_PRICNG_IND

                                                         CODES:
                                                           REFER TO: REV_CNTR_PRICNG_IND_TB
                                                                     IN THE CODES APPENDIX

                                                         SOURCE:
                                                         CWF

220. Revenue Center Obligation   CHAR   1   Effective with Version 'I' the code used
     to Accept As Full (OTAF)   to indicate that the provider was obligated
     Payment Code   to accept as full payment the amount re-
                                                           ceived from the primary (or secondary) payer.

                                                         NOTE: Beginning with NCH weekly process date
                                                         7/7/00, this field will be populated with data.
                                                         Claims processed prior to 7/7/00 will contain
                                                         spaces in this field.

                                                         DB2 ALIAS: REV_OTAF1_IND_CD
                                                         SAS ALIAS: OTAF_1
                                                         STANDARD ALIAS: REV_CNTR_OTAF_1_IND_CD
                                                         TITLE ALIAS: REV_CNTR_OTAF_1_IND_CD

                                                         EDIT-RULES:
                                                         Y = provider is obligated to accept the payment

inpatientsnf.txt
```
                                     as payment in full for the service.
                              N or blank  = provider is not obligated to accept
                                     the payment, or there is no payment by a prior
                                     payer.

                              SOURCE:
                              CWF

   221. Revenue Center Obligation    CHAR     1         ***********FIELD NOT POPULATED*************
        to Accept As Full (OTAF)                        This field was intended to collect information
        Payment Code                                    for two payers if Medicare was tertiary.  It
                                                         was discovered that MSP system only deals with
                                                         one payer so there is no need to have 2 OTAF
                                                         fields.
```

```
                                     POSITIONS
            NAME               TYPE  LENGTH BEG  END                      CONTENTS
   --------------------------- ----  ------ ---------   ------------------------------------------------------

                                                         DB2 ALIAS: REV_OTAF2_IND_CD
                                                         SAS ALIAS: OTAF_2
                                                         STANDARD ALIAS: REV_CNTR_OTAF_2_IND_CD
                                                         TITLE ALIAS: REV_CNTR_OTAF_2_IND_CD

                                                         SOURCE:
                                                         CWF

   222. Revenue Center IDE, NDC,    CHAR    24          Effective with Version H, the exemption number
        UPC Number                                      assigned by the Food and Drug Administration (FDA)
                                                         to an investigational device after a manufacturer
                                                         has been approved by FDA to conduct a clinical
                                                         trial on that device.   HCFA established a new
                                                         policy of covering certain IDE's which was
                                                         implemented in claims processing on 10/1/96
                                                         (which is NCH weekly process 10/4/96) for service
                                                         dates beginning 10/1/95.  IDE's are always
                                                         associated with revenue center code '0624'.

                                                         NOTE1:  Prior to Version H a 'dummy' revenue
                                                         center code '0624' trailer was created to store
                                                         IDE's.   The IDE number was housed in two fields:
                                                         HCPCS code and HCPCS initial modifier; the second
```

         modifier contained the value 'ID'. There can be
         up to 7 distinct IDE numbers associated with an
         '0624' dummy trailer. During the Version H con-
         version IDE's were moved from the dummy '0624'
         trailer to this dedicated field.

         NOTE2: Effective with Version 'I', this field was
         renamed to eventually accommodate the National Drug Code
         (NDC) and the Universal Product Code (UPC). This field
         could contain either of these 3 fields (there would never
         be an instance where more than one would come in on
         a claim). The size of this field was expanded to X(24)
         to accommodate either of the new fields (under Version
         'H' it was X(7). DATA ANAMOLY/LIMITATION: During an
         CWFMQA review an edit revealed the IDE was missing.
         The problem occurs in claim with an NCH weekly pro-
         cess dates of 6/9/00 through 9/8/00. During processing
         of the new format the program receives the IDE but
         then blanked out the data.

         DB2 ALIAS: IDE_NDC_UPC_NUM
         SAS ALIAS: IDENDC
         STANDARD ALIAS: REV_CNTR_IDE_NDC_UPC_NUM
         TITLE ALIAS: IDE_NDC_UPC

         SOURCE:
         CWF

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                                        POSITIONS
              NAME   TYPE LENGTH BEG   END   CONTENTS
     ---------------------------- ---- ------ --------- ---

  223. Revenue Center Unit Count   PACK   4   A quantitative measure (unit) of the number of times the
                                                            service or procedure being reported was performed according
                                                            to the revenue center/HCPCS code definition as described on
                                                            an institutional claim.

                                                            Depending on type of service, units are measured by number
                                                            of covered days in a particular accommodation, pints of
                                                            blood, emergency room visits, clinic visits, dialysis
                                                            treatments (sessions or days), outpatient therapy visits,
                                                            and outpatient clinical diagnostic laboratory tests.

                                      Page 141

NOTE1: When revenue center code = '0022' (SNF PPS) the unit
count will reflect the number of covered days for each HIPPS
code and, if applicable, the number of visits for each rehab
therapy code.

7 DIGITS SIGNED

DB2 ALIAS: REV_CNTR_UNIT_CNT
SAS ALIAS: REV_UNIT
STANDARD ALIAS: REV_CNTR_UNIT_CNT
TITLE ALIAS: UNITS

SOURCE:
CWF

224. Revenue Center Rate Amount   PACK   6   Charges relating to unit cost associated with
the revenue center code. Exception (encounter
data only): If plan (e.g. MCO) does not know
the actual rate for the accommodations, $1 will
be reported in the field.

NOTE1: For SNF PPS claims (when revenue center
code equals '0022'), HCFA has developed a SNF
PRICER to compute the rate based on the provider
supplied coding for the MDS RUGS III group and
assessment type (HIPPS code, stored in revenue
center HCPCS code field).

NOTE2: For OP PPS claims, HCFA has developed a
PRICER to compute the rate based on the Ambulatory
Payment Classification (APC), discount factor,
units of service and the wage index.

NOTE3: Under HH PPS (when revenue center
code equals '0023'), HCFA has developed a HHA
PRICER to compute the rate. On the RAP, the rate is
determined using the case mix weight associated with
the HIPPS code, adjusting it for the wage index
for the beneficiary's site of service, then
multiplying the result by 60% or 50%, depending on
whether or not the RAP is for a first episode.

```
                                    POSITIONS
          NAME              TYPE  LENGTH BEG  END                      CONTENTS
----------------------------  ----  ------ ---------  ------------------------------------------------------------
                                                      On the final claim, the HIPPS code could change the
                                                      payment if the therapy threshold is not met, or
                                                      partial episode payment (PEP) adjustment or a
                                                      significant change in condition (SCIC) adjustment.
                                                      In cases of SCICs, there will be more than one
                                                      '0023' revenue center line, each representing the
                                                      payment made at each case-mix level.

                                                      9.2 DIGITS SIGNED

                                                      DB2 ALIAS: REV_CNTR_RATE_AMT
                                                      SAS ALIAS: REV_RATE
                                                      STANDARD ALIAS: REV_CNTR_RATE_AMT
                                                      TITLE ALIAS: CHARGE_PER_UNIT

                                                      EFFECTIVE-DATE: 10/01/1993

                                                      COMMENT:
                                                      Prior to Version H the size of this field was:
                                                      S9(7)V99.

                                                      SOURCE:
                                                      CWF

225. Revenue Center Blood      PACK      6            Effective with Version 'I', the amount of money
     Deductible Amount                                for which the intermediary determined the
                                                      beneficiary is liable for the blood deductible
                                                      for the line item service.

                                                      NOTE:  Beginning with NCH weekly process date
                                                      7/7/00, this field will be populated with data.
                                                      Claims processed prior to 7/7/00 will contain
                                                      spaces in this field.

                                                      9.2 DIGITS SIGNED

                                                      DB2 ALIAS: REV_BLOOD_DDCTBL
                                                      SAS ALIAS: REVBLOOD
                                                      STANDARD ALIAS: REV_CNTR_BLOOD_DDCTBL_AMT
```

TITLE ALIAS: BLOOD_DDCTBL_AMT

SOURCE:
CWF

226. Revenue Center Cash   PACK   6   Effective with Version 'I' the amount of cash
     Deductible Amount   deductible the beneficiary paid for the line
                                                       item service.

                                                       NOTE: Beginning with NCH weekly process date
                                                       7/7/00, this field will be populated with data.
                                                       Claims processed prior to 7/7/00 will contain
                                                       spaces in this field.

                                                       9.2 DIGITS SIGNED

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                         POSITIONS
              NAME   TYPE LENGTH BEG END   CONTENTS
     --------------------------- ---- ------ --------- ---

                                                       DB2 ALIAS: REV_CASH_DDCTBL
                                                       SAS ALIAS: REVDCTBL
                                                       STANDARD ALIAS: REV_CNTR_CASH_DDCTBL_AMT
                                                       TITLE ALIAS: CASH_DDCTBL

                                                       SOURCE:
                                                       CWF

227. Revenue Center   PACK   6   Effective with Version 'I', the amount of
     Coinsurance/Wage Adjusted   coinsurance applicable to the line item
     Coinsurance Amount   service defined by the revenue center and
                                                       HCPCS codes. For those services subject to
                                                       Outpatient PPS, the applicable coinsurance
                                                       is wage adjusted.

                                                       NOTE1: This field will have either a zero
                                                       (for services for which coinsurance is not
                                                       applicable), a regular coinsurance amount
                                                       (calculated on either charges or a fee
                                                       schedule) or if subject to OP PPS the national
                                                       coinsurance amount will be wage adjusted.
                                                       The wage adjusted coinsurance is based on the
                                                       MSA where the provider is located or assigned

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                                inpatientsnf.txt
                           as a result of a reclassification.

                           NOTE2:  Beginning with NCH weekly process date
                           8/18/00, this field will be populated with data.
                           Claims processed prior to 8/18/00 will contain
                           spaces in this field.

                           9.2 DIGITS SIGNED

                           DB2 ALIAS: ADJSTD_COINSRNC
                           SAS ALIAS: WAGEADJ
                           STANDARD ALIAS: REV_CNTR_WAGE_ADJSTD_COINS_AMT
                           TITLE ALIAS: WAGE_ADJSTD_COINS

                           SOURCE:
                           CWF

   228. Revenue Center Reduced      PACK       6        Effective with Version 'I', for all services
        Coinsurance Amount                              subject to Outpatient PPS, the amount of
                                                        coinsurance applicable to the line for a
                                                        particular service (HCPCS) for which the
                                                        provider has elected to reduce the coinsurance
                                                        amount.

                                                        NOTE1:  The reduced coinsurance amount cannot
                                                        be lower than 20% of the payment rate for the
                                                        APC line.
```

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                                      POSITIONS
              NAME              TYPE  LENGTH BEG  END                         CONTENTS
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                                                        NOTE2:  Beginning with NCH weekly process date
                                                        8/18/00, this field will be populated with data.
                                                        Claims processed prior to 8/18/00 will contain
                                                        spaces in this field.

                                                        9.2 DIGITS SIGNED

                                                        DB2 ALIAS: RDCD_COINSRNC
                                                        SAS ALIAS: RDCDCOIN
                                                        STANDARD ALIAS: REV_CNTR_RDCD_COINS_AMT
```

inpatientsnf.txt
                              TITLE ALIAS: REDUCED_COINS

                              SOURCE:
                              CWF

229. Revenue Center 1st Medicare   PACK   6   Effective with Version 'I', the amount paid by
     Secondary Payer Paid   the primary payer when the payer is primary to
     Amount   Medicare (Medicare is secondary or tertiary).

                                                   NOTE: Beginning with NCH weekly process date
                                                   7/7/00, this field will be populated with data.
                                                   Claims processed prior to 7/7/00 will contain
                                                   spaces in this field.

                                                   9.2 DIGITS SIGNED

                                                   DB2 ALIAS: REV_MSP1_PD_AMT
                                                   SAS ALIAS: REV_MSP1
                                                   STANDARD ALIAS: REV_CNTR_MSP1_PD_AMT
                                                   TITLE ALIAS: MSP PAID AMOUNT

                                                   SOURCE:
                                                   CWF

230. Revenue Center 2nd Medicare   PACK   6   Effective with Version 'I', the amount paid by
     Secondary Payer Paid   the secondary payer when two payers are primary
     Amount   to Medicare (Medicare is the tertiary payer).

                                                   NOTE: Beginning with NCH weekly process date
                                                   7/7/00, this field will be populated with data.
                                                   Claims processed prior to 7/7/00 will contain
                                                   spaces in this field.

                                                   9.2 DIGITS SIGNED

                                                   DB2 ALIAS: REV_MSP2_PD_AMT
                                                   SAS ALIAS: REV_MSP2
                                                   STANDARD ALIAS: REV_CNTR_MSP2_PD_AMT
                                                   TITLE ALIAS: MSP PAID AMOUNT

                                                   SOURCE:
                                                   CWF

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

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                                    POSITIONS
            NAME             TYPE  LENGTH BEG  END                        CONTENTS
------------------------------ ----  ------ ---------   --------------------------------------------------------

231. Revenue Center Professional  PACK     6                 ************FIELD NOT POPULATED*************
     Component Amount                                        Intended to be populated for line item services
                                                             subject to PPS, as the amount associated with
                                                             Value Code '05'.  However, with line item date
                                                             of service reporting, there is no way to
                                                             correctly allocate professional component charges
                                                             reported in value code '05' to specific line items
                                                             on the claim.

                                                             9.2 DIGITS SIGNED

                                                             DB2 ALIAS: REV_PROFNL_CMPNT
                                                             SAS ALIAS: REVPCCHG
                                                             STANDARD ALIAS: REV_CNTR_PROFNL_CMPNT_AMT
                                                             TITLE ALIAS: PROFNL_CMPNT_CHARGES

                                                             SOURCE:
                                                             CWF

232. Revenue Center Provider      PACK     6                 Effective with Version 'I', the amount paid
     Payment Amount                                          to the provider for the services reported
                                                             on the line item.

                                                             NOTE:  Beginning with NCH weekly process date
                                                             7/7/00, this field will be populated with data.
                                                             Claims processed prior to 7/7/00 will contain
                                                             spaces in this field.

                                                             9.2 DIGITS SIGNED

                                                             DB2 ALIAS: REV_PRVDR_PMT_AMT
                                                             SAS ALIAS: RPRVDPMT
                                                             STANDARD ALIAS: REV_CNTR_PRVDR_PMT_AMT
                                                             TITLE ALIAS: REV_PRVDR_PMT

                                                             SOURCE:
                                                             CWF

233. Revenue Center Beneficiary   PACK     6                 Effective with Version I, the amount paid
```

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                                          inpatientsnf.txt
     Payment Amount                        to the beneficiary for the services reported
                                           on the line item.

                                           NOTE:  Beginning with NCH weekly process date
                                           7/7/00, this field will be populated with data.
                                           Claims processed prior to 7/7/00 will contain
                                           spaces in this field.

                                           9.2 DIGITS SIGNED

                                           DB2 ALIAS: REV_BENE_PMT_AMT
                                           SAS ALIAS: RBENEPMT
                                           STANDARD ALIAS: REV_CNTR_BENE_PMT_AMT
                                           TITLE ALIAS: REV_BENE_PMT
```

1   FI Inpatient SNF Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

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                                     POSITIONS
          NAME               TYPE  LENGTH BEG  END                        CONTENTS
   ---------------------------  ----  ------ ---------  ------------------------------------------------------------

                                           SOURCE:
                                           CWF

   234. Revenue Center Patient    PACK     6           Effective with Version I, the amount paid
        Responsibility Payment                         by the beneficiary to the provider for the
        Amount                                         line item service.

                                           NOTE:  Beginning with NCH weekly process date
                                           7/7/00 this field was populated with data.
                                           Claims processed prior to 7/7/00 will contain
                                           zeroes in this field.

                                           9.2 DIGITS SIGNED

                                           DB2 ALIAS: REV_PTNT_RESP_AMT
                                           SAS ALIAS: PTNTRESP
                                           STANDARD ALIAS: REV_CNTR_PTNT_RESP_PMT_AMT
                                           TITLE ALIAS: REV_PTNT_RESP

                                           SOURCE:
                                           CWF

   235. Revenue Center Payment    PACK     6           Effective with Version 'I', the line item
```

```
                                 inpatientsnf.txt
  Amount                         Medicare payment amount for the specific
                                 revenue center.

                                 Under OP PPS, PRICER will compute the
                                 standard OPPS payment for a line item based
                                 on the payment APC.

                                 Under HH PPS, PRICER will compute/return
                                 a line item payment amount for the case-mixed,
                                 wage-index adjusted HIPPS code assigned to
                                 the '0023' revenue center line.  The HIPPS
                                 code will be stored in the Revenue Center
                                 HCPCS code field.

                                 9.2 DIGITS SIGNED

                                 COMMON ALIAS: REIMBURSEMENT
                                 DB2 ALIAS: REV_CNTR_PMT_AMT
                                 SAS ALIAS: REVPMT
                                 STANDARD ALIAS: REV_CNTR_PMT_AMT
                                 TITLE ALIAS: REIMBURSEMENT

                                 EDIT-RULES:
                                 $$$$$$$$$CC

                                 SOURCE:
                                 CWF
```

```
                                      POSITIONS
            NAME            TYPE  LENGTH BEG   END                     CONTENTS
    ---------------------------- ----  ------ ---------  -------------------------------------------------------
```

NAME	TYPE	LENGTH	BEG	END	CONTENTS
236. Revenue Center Total Charge Amount	PACK	6			The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided. NOTE: For accommodation revenue center total charges must equal the rate times units (days).

```
                                 EXCEPTIONS:
                                 (1)  For SNF RUGS demo claims only (9000 series revenue
                                 center codes), this field contains SNF customary
```

inpatientsnf.txt
accommodation charge, (ie., charges related to the
accommodation revenue center code that would have been
applicable if the provider had not been participating in the
demo).

(2) For SNF PPS (non demo claims), when revenue center code
= '0022', the total charges will be zero.

(3) For Home Health PPS (RAPs), when revenue center code =
'0023', the total charges will equal the dollar amount for
the '0023' line.

(4) For Home Health PPS (final claim), when revenue center
code = '0023', the total charges will be the sum of the
revenue center code lines (other than '0023').

(5) For encounter data, if the plan (e.g. MCO) does not
know the actual charges for the accommodations the total
charges will be $1 (rate) times units (days).

9.2 DIGITS SIGNED

DB2 ALIAS: REV_TOT_CHRG_AMT
SAS ALIAS: REV_CHRG
STANDARD ALIAS: REV_CNTR_TOT_CHRG_AMT
TITLE ALIAS: REVENUE_CENTER_CHARGES

EDIT-RULES:
$$$$$$$$$CC

COMMENT:
Prior to Version H the size of this field was:
S9(7)V99.

SOURCE:
CWF

237. Revenue Center Non-Covered   PACK   6   The charge amount related to a revenue center code for
     Charge Amount   services that are not covered by Medicare.

                                                       NOTE: Prior to Version H the field size was S9(7)V99 and
                                                       the element was only present on the Inpatient/SNF format.
                                                       As of NCH weekly process date 10/3/97 this field was added
                                                       to all institutional claim types.

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                                       POSITIONS
            NAME              TYPE  LENGTH BEG   END                        CONTENTS
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```

                                                  9.2 DIGITS SIGNED

                                                  DB2 ALIAS: REV_NCVR_CHRG_AMT
                                                  SAS ALIAS: REV_NCVR
                                                  STANDARD ALIAS: REV_CNTR_NCVR_CHRG_AMT
                                                  TITLE ALIAS: REV_CENTER_NONCOVERED_CHARGES

                                                  EDIT-RULES:
                                                  $$$$$$$$$CC

                                                  SOURCE:
                                                  CWF

238. Revenue Center Deductible   CHAR   1   Code indicating whether the revenue center charges
     Coinsurance Code   are subject to deductible and/or coinsurance.

                                                  DB2 ALIAS: DDCTBL_COINSRNC_CD
                                                  SAS ALIAS: REVDEDCD
                                                  STANDARD ALIAS: REV_CNTR_DDCTBL_COINSRNC_CD
                                                  TITLE ALIAS: REVENUE_CENTER_DEDUCTIBLE_CD

                                                  CODES:
                                                    REFER TO: REV_CNTR_DDCTBL_COINSRNC_TB
                                                              IN THE CODES APPENDIX

                                                  SOURCE:
                                                  CWF

239. FILLER   CHAR   50

240. End of Record Code   CHAR   3   Effective with Version 'I', the code used
                                                  to identify the end of a record/segment or
                                                  the end of the claim.

                                                  DB2 ALIAS: END_REC_CD
                                                  SAS ALIAS: EOR
                                                  STANDARD ALIAS: END_REC_CD

```
                            inpatientsnf.txt
                        TITLE ALIAS: END_OF_REC

                        CODES:
                        EOR = End of Record/Segment
                        EOC= End of Claim

                        COMMENT:
                        Prior to Version I this field was named:
                        END_REC_CNSTNT.

                        SOURCE:
                        NCH

1       BENE_IDENT_TB                   Beneficiary Identification Code (BIC) Table
        -------------                   --------------------------------------------

                        Social Security Administration:

                        A  = Primary claimant
                        B  = Aged wife, age 62 or over (1st
                             claimant)
                        B1 = Aged husband, age 62 or over (1st
                             claimant)
                        B2 = Young wife, with a child in her care
                             (1st claimant)
                        B3 = Aged wife (2nd claimant)
                        B4 = Aged husband (2nd claimant)
                        B5 = Young wife (2nd claimant)
                        B6 = Divorced wife, age 62 or over (1st
                             claimant)
                        B7 = Young wife (3rd claimant)
                        B8 = Aged wife (3rd claimant)
                        B9 = Divorced wife (2nd claimant)
                        BA = Aged wife (4th claimant)
                        BD = Aged wife (5th claimant)
                        BG = Aged husband (3rd claimant)
                        BH = Aged husband (4th claimant)
                        BJ = Aged husband (5th claimant)
                        BK = Young wife (4th claimant)
                        BL = Young wife (5th claimant)
                        BN = Divorced wife (3rd claimant)
                        BP = Divorced wife (4th claimant)
                        BQ = Divorced wife (5th claimant)
                        BR = Divorced husband (1st claimant)

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                        BT = Divorced husband (2nd claimant)
                        BW = Young husband (2nd claimant)
                        BY = Young husband (1st claimant)
                        C1-C9,CA-CZ = Child (includes minor, student
                                  or disabled child)
                        D  = Aged widow, 60 or over (1st claimant)
                        D1 = Aged widower, age 60 or over (1st
                             claimant)
                        D2 = Aged widow (2nd claimant)
                        D3 = Aged widower (2nd claimant)
                        D4 = Widow (remarried after attainment of
                             age 60) (1st claimant)
                        D5 = Widower (remarried after attainment of
                             age 60) (1st claimant)
                        D6 = Surviving divorced wife, age 60 or over
                             (1st claimant)
                        D7 = Surviving divorced wife (2nd claimant)
                        D8 = Aged widow (3rd claimant)
                        D9 = Remarried widow (2nd claimant)
                        DA = Remarried widow (3rd claimant)
                        DC = Surviving divorced husband (1st claimant)
                        DD = Aged widow (4th claimant)
                        DG = Aged widow (5th claimant)
                        DH = Aged widower (3rd claimant)
                        DJ = Aged widower (4th claimant)
                        DK = Aged widower (5th claimant)
                        DL = Remarried widow (4th claimant)
                        DM = Surviving divorced husband (2nd
                             claimant)
                        DN = Remarried widow (5th claimant)
1        BENE_IDENT_TB                Beneficiary Identification Code (BIC) Table
         -------------                --------------------------------------------

                        DP = Remarried widower (2nd claimant)
                        DQ = Remarried widower (3rd claimant)
                        DR = Remarried widower (4th claimant)
                        DS = Surviving divorced husband (3rd
                             claimant)
                        DT = Remarried widower (5th claimant)
                        DV = Surviving divorced wife (3rd claimant)
                        DW = Surviving divorced wife (4th claimant)
                        DX = Surviving divorced husband (4th
                             claimant)
                        DY = Surviving divorced wife (5th claimant)
```

```
DZ = Surviving divorced husband (5th
     claimant)
E  = Mother (widow) (1st claimant)
E1 = Surviving divorced mother (1st
     claimant)
E2 = Mother (widow) (2nd claimant)
E3 = Surviving divorced mother (2nd
     claimant)
E4 = Father (widower) (1st claimant)
E5 = Surviving divorced father (widower)
     (1st claimant)
E6 = Father (widower) (2nd claimant)
E7 = Mother (widow) (3rd claimant)
E8 = Mother (widow) (4th claimant)
E9 = Surviving divorced father (widower)
     (2nd claimant)
EA = Mother (widow) (5th claimant)
EB = Surviving divorced mother (3rd
     claimant)
EC = Surviving divorced mother (4th
     claimant)
ED = Surviving divorced mother (5th
     claimant
EF = Father (widower) (3rd claimant)
EG = Father (widower) (4th claimant)
EH = Father (widower) (5th claimant)
EJ = Surviving divorced father (3rd
     claimant)
EK = Surviving divorced father (4th
     claimant)
EM = Surviving divorced father (5th
     claimant)
F1 = Father
F2 = Mother
F3 = Stepfather
F4 = Stepmother
F5 = Adopting father
F6 = Adopting mother
F7 = Second alleged father
F8 = Second alleged mother
J1 = Primary prouty entitled to HIB
     (less than 3 Q.C.) (general fund)
J2 = Primary prouty entitled to HIB
     (over 2 Q.C.) (RSI trust fund)
```

```
                                         J3 = Primary prouty not entitled to HIB
                                              (less than 3 Q.C.) (general fund)
                                         J4 = Primary prouty not entitled to HIB
1            BENE_IDENT_TB                     Beneficiary Identification Code (BIC) Table
             -------------                     --------------------------------------------

                                              (over 2 Q.C.) (RSI trust fund)
                                         K1 = Prouty wife entitled to HIB (less than
                                              3 Q.C.) (general fund) (1st claimant)
                                         K2 = Prouty wife entitled to HIB (over 2
                                              Q.C.) (RSI trust fund) (1st claimant)
                                         K3 = Prouty wife not entitled to HIB (less
                                              than 3 Q.C.) (general fund) (1st
                                              claimant)
                                         K4 = Prouty wife not entitled to HIB (over
                                              2 Q.C.) (RSI trust fund) (1st
                                              claimant)
                                         K5 = Prouty wife entitled to HIB (less than
                                              3 Q.C.) (general fund) (2nd claimant)
                                         K6 = Prouty wife entitled to HIB (over 2
                                              Q.C.) (RSI trust fund) (2nd claimant)
                                         K7 = Prouty wife not entitled to HIB (less
                                              than 3 Q.C.) (general fund) (2nd
                                              claimant)
                                         K8 = Prouty wife not entitled to HIB (over
                                              2 Q.C.) (RSI trust fund) (2nd
                                              claimant)
                                         K9 = Prouty wife entitled to HIB (less than
                                              3 Q.C.) (general fund) (3rd claimant)
                                         KA = Prouty wife entitled to HIB (over 2
                                              Q.C.) (RSI trust fund) (3rd claimant)
                                         KB = Prouty wife not entitled to HIB (less
                                              than 3 Q.C.) (general fund) (3rd
                                              claimant)
                                         KC = Prouty wife not entitled to HIB (over
                                              2 Q.C.) (RSI trust fund) (3rd
                                              claimant)
                                         KD = Prouty wife entitled to HIB (less than
                                              3 Q.C.) (general fund) (4th claimant)
                                         KE = Prouty wife entitled to HIB (over 2 Q.C
                                              (4th claimant)
                                         KF = Prouty wife not entitled to HIB (less
                                              than 3 Q.C.)(4th claimant)
                                         KG = Prouty wife not entitled to HIB (over
```

```
                                2 Q.C.)(4th claimant)
                         KH = Prouty wife entitled to HIB (less than
                                3 Q.C.)(5th claimant)
                         KJ = Prouty wife entitled to HIB (over 2
                                Q.C.) (5th claimant)
                         KL = Prouty wife not entitled to HIB (less
                                than 3 Q.C.)(5th claimant)
                         KM = Prouty wife not entitled to HIB (over
                                2 Q.C.) (5th claimant)
                         M  = Uninsured-not qualified for deemed HIB
                         M1 = Uninsured-qualified but refused HIB
                         T  = Uninsured-entitled to HIB under deemed
                                or renal provisions
                         TA = MQGE (primary claimant)
                         TB = MQGE aged spouse (first claimant)
                         TC = MQGE disabled adult child (first claimant)
                         TD = MQGE aged widow(er) (first claimant)
                         TE = MQGE young widow(er) (first claimant)
                         TF = MQGE parent (male)
                         TG = MQGE aged spouse (second claimant)
```

1	BENE_IDENT_TB	Beneficiary Identification Code (BIC) Table
	-------------	---

```
                         TH = MQGE aged spouse (third claimant)
                         TJ = MQGE aged spouse (fourth claimant)
                         TK = MQGE aged spouse (fifth claimant)
                         TL = MQGE aged widow(er) (second claimant)
                         TM = MQGE aged widow(er) (third claimant)
                         TN = MQGE aged widow(er) (fourth claimant)
                         TP = MQGE aged widow(er) (fifth claimant)
                         TQ = MQGE parent (female)
                         TR = MQGE young widow(er) (second claimant)
                         TS = MQGE young widow(er) (third claimant)
                         TT = MQGE young widow(er) (fourth claimant)
                         TU = MQGE young widow(er) (fifth claimant)
                         TV = MQGE disabled widow(er) fifth claimant
                         TW = MQGE disabled widow(er) first claimant
                         TX = MQGE disabled widow(er) second claimant
                         TY = MQGE disabled widow(er) third claimant
                         TZ = MQGE disabled widow(er) fourth claimant
                         T2-T9 = Disabled child (second to ninth
                                   claimant)
                         W  = Disabled widow, age 50 or over (1st
                                claimant)
```

```
            W1 = Disabled widower, age 50 or over (1st
                 claimant)
            W2 = Disabled widow (2nd claimant)
            W3 = Disabled widower (2nd claimant)
            W4 = Disabled widow (3rd claimant)
            W5 = Disabled widower (3rd claimant)
            W6 = Disabled surviving divorced wife (1st
                 claimant)
            W7 = Disabled surviving divorced wife (2nd
                 claimant)
            W8 = Disabled surviving divorced wife (3rd
                 claimant)
            W9 = Disabled widow (4th claimant)
            WB = Disabled widower (4th claimant)
            WC = Disabled surviving divorced wife (4th
                 claimant)
            WF = Disabled widow (5th claimant)
            WG = Disabled widower (5th claimant)
            WJ = Disabled surviving divorced wife (5th
                 claimant)
            WR = Disabled surviving divorced husband
                 (1st claimant)
            WT = Disabled surviving divorced husband
                 (2nd claimant)


         Railroad Retirement Board:

            NOTE:
            Employee:  a Medicare beneficiary who is
                       still working or a worker who
                       died before retirement
            Annuitant: a person who retired under the
                       railroad retirement act on or
                       after 03/01/37
            Pensioner: a person who retired prior to
                       03/01/37 and was included in the
                       railroad retirement act
1        BENE_IDENT_TB            Beneficiary Identification Code (BIC) Table
         -------------            -------------------------------------------


            10 = Retirement - employee or annuitant
            80 = RR pensioner (age or disability)
            14 = Spouse of RR employee or annuitant
```

                              Page 157

```
                     (husband or wife)
           84 = Spouse of RR pensioner
           43 = Child of RR employee
           13 = Child of RR annuitant
           17 = Disabled adult child of RR annuitant
           46 = Widow/widower of RR employee
           16 = Widow/widower of RR annuitant
           86 = Widow/widower of RR pensioner
           43 = Widow of employee with a child in her care
           13 = Widow of annuitant with a child in her care
           83 = Widow of pensioner with a child in her care
           45 = Parent of employee
           15 = Parent of annuitant
           85 = Parent of pensioner
           11 = Survivor joint annuitant
                     (reduced benefits taken to insure benefits
                     for surviving spouse)
```

```
1      BENE_PRMRY_PYR_TB                          Beneficiary Primary Payer Table
       -----------------                          ------------------------------
```

```
           A = Working aged bene/spouse with employer
               group health plan (EGHP)
           B = End stage renal disease (ESRD) beneficiary
               in the 18 month coordination period with
               an employer group health plan
           C = Conditional payment by Medicare; future
               reimbursement expected
           D = Automobile no-fault (eff. 4/97; Prior
               to 3/94, also included any liability
               insurance)
           E = Workers' compensation
           F = Public Health Service or other federal
               agency (other than Dept. of Veterans
               Affairs)
           G = Working disabled bene (under age 65
               with LGHP)
           H = Black Lung
           I = Dept. of Veterans Affairs
           J = Any liability insurance
               (eff. 3/94 - 3/97)
           L = Any liability insurance (eff. 4/97)
               (eff. 12/90 for carrier claims and 10/93
```

for FI claims; obsoleted for all claim
types 7/1/96)

M = Override code: EGHP services involved
(eff. 12/90 for carrier claims and 10/93
for FI claims; obsoleted for all claim
types 7/1/96)

N = Override code: non-EGHP services involved
(eff. 12/90 for carrier claims and 10/93
for FI claims; obsoleted for all claim
types 7/1/96)

BLANK = Medicare is primary payer (not sure
of effective date: in use 1/91, if
not earlier)

T = MSP cost avoided - IEQ contractor
(eff. 7/96 carrier claims only)
U = MSP cost avoided - HMO rate cell adjust-
ment contractor (eff. 7/96 carrier claims
only)
V = MSP cost avoided - litigation settlement
contractor (eff. 7/96 carrier claims
only)

X = MSP cost avoided override code (eff.
12/90 for carrier claims and 10/93 for
FI claims; obsoleted for all claim types
7/1/96)

Prior to 12/90

Y = Other secondary payer investigation
shows Medicare as primary payer

1   BENE_PRMRY_PYR_TB   Beneficiary Primary Payer Table
     -----------------   -------------------------------

Z = Medicare is primary payer

NOTE: Values C, M, N, Y, Z and BLANK
indicate Medicare is primary payer.
(values Z and Y were used prior to
12/90. BLANK was suppose to be

effective after 12/90, but may have
been used prior to that date.)

1   BETOS_TB   BETOS Table
           --------   -----------

                        M1A = Office visits - new
                        M1B = Office visits - established
                        M2A = Hospital visit - initial
                        M2B = Hospital visit - subsequent
                        M2C = Hospital visit - critical care
                        M3 = Emergency room visit
                        M4A = Home visit
                        M4B = Nursing home visit
                        M5A = Specialist - pathology
                        M5B = Specialist - psychiatry
                        M5C = Specialist - opthamology
                        M5D = Specialist - other
                        M6 = Consultations
                        P0 = Anesthesia
                        P1A = Major procedure - breast
                        P1B = Major procedure - colectomy
                        P1C = Major procedure - cholecystectomy
                        P1D = Major procedure - turp
                        P1E = Major procedure - hysterctomy
                        P1F = Major procedure - explor/decompr/excisdisc
                        P1G = Major procedure - Other
                        P2A = Major procedure, cardiovascular-CABG
                        P2B = Major procedure, cardiovascular-Aneurysm repair
                        P2C = Major Procedure, cardiovascular-Thromboendarterectomy
                        P2D = Major procedure, cardiovascualr-Coronary angioplasty (PTCA)
                        P2E = Major procedure, cardiovascular-Pacemaker insertion
                        P2F = Major procedure, cardiovascular-Other
                        P3A = Major procedure, orthopedic - Hip fracture repair
                        P3B = Major procedure, orthopedic - Hip replacement
                        P3C = Major procedure, orthopedic - Knee replacement
                        P3D = Major procedure, orthopedic - other
                        P4A = Eye procedure - corneal transplant
                        P4B = Eye procedure - cataract removal/lens insertion
                        P4C = Eye procedure - retinal detachment
                        P4D = Eye procedure - treatment
                        P4E = Eye procedure - other
                        P5A = Ambulatory procedures - skin

```
                P5B = Ambulatory procedures - musculoskeletal
                P5C = Ambulatory procedures - inguinal hernia repair
                P5D = Ambulatory procedures - lithotripsy
                P5E = Ambulatory procedures - other
                P6A = Minor procedures - skin
                P6B = Minor procedures - musculoskeletal
                P6C = Minor procedures - other (Medicare fee schedule)
                P6D = Minor procedures - other (non-Medicare fee schedule)
                P7A = Oncology - radiation therapy
                P7B = Oncology - other
                P8A = Endoscopy - arthroscopy
                P8B = Endoscopy - upper gastrointestinal
                P8C = Endoscopy - sigmoidoscopy
                P8D = Endoscopy - colonoscopy
                P8E = Endoscopy - cystoscopy
                P8F = Endoscopy - bronchoscopy
                P8G = Endoscopy - laparoscopic cholecystectomy
                P8H = Endoscopy - laryngoscopy
                P8I = Endoscopy - other
                P9A = Dialysis services
```

1   BETOS_TB   BETOS Table
           --------   -----------

```
                I1A = Standard imaging - chest
                I1B = Standard imaging - musculoskeletal
                I1C = Standard imaging - breast
                I1D = Standard imaging - contrast gastrointestinal
                I1E = Standard imaging - nuclear medicine
                I1F = Standard imaging - other
                I2A = Advanced imaging - CAT: head
                I2B = Advanced imaging - CAT: other
                I2C = Advanced imaging - MRI: brain
                I2D = Advanced imaging - MRI: other
                I3A = Echography - eye
                I3B = Echography - abdomen/pelvis
                I3C = Echography - heart
                I3D = Echography - carotid arteries
                I3E = Echography - prostate, transrectal
                I3F = Echography - other
                I4A = Imaging/procedure - heart including cardiac
                                    catheter
                I4B = Imaging/procedure - other
                T1A = Lab tests - routine venipuncture (non Medicare
                            fee schedule)
```

```
                T1B = Lab tests - automated general profiles
                T1C = Lab tests - urinalysis
                T1D = Lab tests - blood counts
                T1E = Lab tests - glucose
                T1F = Lab tests - bacterial cultures
                T1G = Lab tests - other (Medicare fee schedule)
                T1H = Lab tests - other (non-Medicare fee schedule)
                T2A = Other tests - electrocardiograms
                T2B = Other tests - cardiovascular stress tests
                T2C = Other tests - EKG monitoring
                T2D = Other tests - other
                D1A = Medical/surgical supplies
                D1B = Hospital beds
                D1C = Oxygen and supplies
                D1D = Wheelchairs
                D1E = Other DME
                D1F = Orthotic devices
                O1A = Ambulance
                O1B = Chiropractic
                O1C = Enteral and parenteral
                O1D = Chemotherapy
                O1E = Other drugs
                O1F = Vision, hearing and speech services
                O1G = Influenza immunization
                Y1  = Other - Medicare fee schedule
                Y2  = Other - non-Medicare fee schedule
                Z1  = Local codes
                Z2  = Undefined codes
```

```
1      CARR_CLM_PMT_DNL_TB                          Carrier Claim Payment Denial Table
       -------------------                          ----------------------------------


                0 = Denied
                1 = Physician/supplier
                2 = Beneficiary
                3 = Both physician/supplier and beneficiary
                4 = Hospital (hospital based physicians)
                5 = Both hospital and beneficiary
                6 = Group practice prepayment plan
                7 = Other entries (e.g. Employer, union)
                8 = Federally funded
                9 = PA service
                A = Beneficiary under limitation of
```

                    liability
     B = Physician/supplier under limitation of
         liability
     D = Denied due to demonstration involvement
         (eff. 5/97)
     E = MSP cost avoided IRS/SSA/HCFA Data
         Match (eff. 7/3/00)
     F = MSP cost avoided HMO Rate Cell
         (eff. 7/3/00)
     G = MSP cost avoided Litigation Settlement
         (eff. 7/3/00)
     H = MSP cost avoided Employer Voluntary
         Reporting (eff. 7/3/00)
     J = MSP cost avoided Insurer Voluntary
         Reporting (eff. 7/3/00)
     K = MSP cost avoided Initial Enrollment
         Questionnaire (eff. 7/3/00)
     P = Physician ownership denial (eff 3/92)
     Q = MSP cost avoided - (Contractor #88888)
         voluntary agreement (eff. 1/98)
     T = MSP cost avoided - IEQ contractor
         (eff. 7/96) (obsolete 6/30/00)
     U = MSP cost avoided - HMO rate cell
         adjustment (eff. 7/96) (obsolete 6/30/00)
     V = MSP cost avoided - litigation
         settlement (eff. 7/96) (obsolete 6/30/00)
     X = MSP cost avoided - generic
     Y = MSP cost avoided - IRS/SSA data
         match project (obsolete 6/30/00)

1   CARR_LINE_PRVDR_TYPE_TB   Carrier Line Provider Type Table
    ------------------------   --------------------------------

                    For Physician/Supplier (RIC O) Claims:

                    0 = Clinics, groups, associations,
                        partnerships, or other entities
                    1 = Physicians or suppliers reporting as
                        solo practitioners
                    2 = Suppliers (other than sole proprietorship)
                    3 = Institutional provider
                    4 = Independent laboratories
                    5 = Clinics (multiple specialties)

```
6 = Groups (single specialty)
7 = Other entities

For DMERC (RIC M) Claims - PRIOR TO VERSION H:

0 = Clinics, groups, associations,
      partnerships, or other entities
      for whom the carrier's own ID number
      has been assigned.
1 = Physicians or suppliers billing as
      solo practitioners for whom SSN's are
      shown in the physician ID code field.
2 = Physicians or suppliers billing as
      solo practitioners for whom the carrier's
      own physician ID code is shown.
3 = Suppliers (other than sole proprietorship)
      for whom EI numbers are used in coding the
      ID field.
4 = Suppliers (other than sole proprietorship)
      for whom the carrier's own code has been
      shown.
5 = Institutional providers and
      independent laboratories for whom EI
      numbers are used in coding the ID field.
6 = Institutional providers and
      independent laboratories for whom the
      carrier's own ID number is shown.
7 = Clinics, groups, associations, or
      partnerships for whom EI numbers
      are used in coding the ID field.
8 = Other entities for whom EI numbers
      are used in coding the ID field or
      proprietorship for whom EI numbers are
      used in coding the ID field.
```

```
1CARR_LINE_RDCD_PHYSN_ASTNT_TB        Carrier Line Part B Reduced Physician Assistant Table
 ----------------------------         -------------------------------------------------------


                                      BLANK = Adjustment situation (where
                                              CLM_DISP_CD equal 3)
                                      0 = N/A
                                      1 = 65%
                                          A) Physician assistants assisting in
```

                              surgery
                    B) Nurse midwives
            2 = 75%
                    A) Physician assistants performing
                       services in a hospital (other than
                       assisting surgery)
                    B) Nurse practitioners and clinical
                       nurse specialists performing
                       services in rural areas
                    C) Clinical social worker services
            3 = 85%
                    A) Physician assistant services for
                       other than assisting surgery
                    B) Nurse practitioners services

1   CARR_NUM_TB   Carrier Number Table
        -----------   --------------------

                    00510 = Alabama BS (eff. 1983)
                    00511 = Georgia - Alabama BS (eff. 1998)
                    00512 = Mississippi - Alabama BS (eff. 2000)
                    00520 = Arkansas BS (eff. 1983)
                    00521 = New Mexico - Arkansas BS (eff. 1998)
                    00522 = Oklahoma - Arkansas BS (eff. 1998)
                    00523 = Missouri - Arkansas BS (eff. 1999)
                    00528 = Louisianna - Arkansas BS (eff. 1984)
                    00542 = California BS (eff. 1983; term. 1996)
                    00550 = Colorado BS (eff. 1983; term. 1994)
                    00570 = Delaware - Pennsylvania BS (eff. 1983;
                              term. 1997)
                    00580 = District of Columbia - Pennsylvania BS
                              (eff. 1983; term. 1997)
                    00590 = Florida BS (eff. 1983)
                    00591 = Connecticut - Florida BS (eff. 2000)
                    00621 = Illinois BS - HCSC (eff. 1983; term. 1998)
                    00623 = Michigan - Illinois Blue Shield (eff. 1995)
                              (term. 1998)
                    00630 = Indiana - Administar (eff. 1983)
                    00635 = DMERC-B (Administar Federal, Inc.)
                              (eff. 1993)
                    00640 = Iowa - Wellmark, Inc. (eff. 1983; term. 1998)
                    00645 = Nebraska - Iowa BS (eff. 1985; term. 1987)
                    00650 = Kansas BS (eff. 1983)

                              Page 165

```
00655 = Nebraska - Kansas BS (eff. 1988)
00660 = Kentucky - Administar (eff. 1983)
00690 = Maryland BS (eff. 1983; term. 1994)
00700 = Massachusetts BS (eff. 1983; term. 1997)
00710 = Michigan BS (eff. 1983; term. 1994)
00720 = Minnesota BS (eff. 1983; term. 1995)
00740 = Missouri - BS Kansas City (eff. 1983)
00751 = Montana BS (eff. 1983)
00770 = New Hampshire/Vermont Physician Services
        (eff. 1983; term. 1984)
00780 = New Hampshire/Vermont - Massachusetts BS
        (eff. 1985; term. 1997)
00801 = New York - Western BS (eff. 1983)
00803 = New York - Empire BS (eff. 1983)
00805 = New Jersey - Empire BS (eff. 3/99)
00811 = DMERC (A) - Western New York BS (eff. 2000)
00820 = North Dakota - North Dakota BS (eff. 1983)
00824 = Colorado - North Dakota BS (eff. 1995)
00825 = Wyoming - North Dakota BS (eff. 1990)
00826 = Iowa - North Dakota BS (eff. 1999)
00831 = Alaska - North Dakota BS (eff. 1998)
00832 = Arizona -  North Dakota BS (eff. 1998)
00833 = Hawaii - North Dakota BS (eff. 1998)
00834 = Nevada - North Dakota BS (eff. 1998)
00835 = Oregon - North Dakota BS (eff. 1998)
00836 = Washington - North Dakota BS (eff. 1998)
00860 = New Jersey - Pennsylvania BS (eff. 1988;
        term. 1999)
00865 = Pennsylvania BS (eff. 1983)
00870 = Rhode Island BS (eff. 1983)
00880 = South Carolina BS (eff. 1983)
00882 = RRB - South Carolina PGBA (eff. 2000)
```

1	CARR_NUM_TB	Carrier Number Table
	-----------	--------------------

```
00885 = DMERC C - Palmetto (eff. 1993)
00900 = Texas BS (eff. 1983)
00901 = Maryland - Texas BS (eff. 1995)
00902 = Delaware - Texas BS (eff. 1998)
00903 = District of Columbia - Texas BS (eff. 1998)
00904 = Virginia - Texas BS (eff. 2000)
00910 = Utah  BS (eff. 1983)
00951 = Wisconsin - Wisconsin Phy Svc (eff. 1983)
00952 = Illinois - Wisconsin Phy Svc (eff. 1999)
```

```
00953 = Michigan - Wisconsin Phy Svc (eff. 1999)
00954 = Minnesota - Wisconsin Phy Svc (eff. 2000)
00973 = Triple-S, Inc. - Puerto Rico (eff. 1983)
00974 = Triple-S, Inc. - Virgin Islands
01020 = Alaska - AETNA (eff. 1983; term. 1997)
01030 = Arizona - AETNA (eff. 1983; term. 1997)
01040 = Georgia - AETNA (eff. 1988; term. 1997)
01120 = Hawaii - AETNA (eff. 1983; term. 1997)
01290 = Nevada - AETNA (eff. 1983; term. 1997)
01360 = New Mexico - AETNA (eff. 1986; term. 1997)
01370 = Oklahoma - AETNA (eff. 1983; term. 1997)
01380 = Oregon - AETNA (eff. 1983; term. 1997
01390 = Washington - AETNA (eff. 1994; term. 1997)
02050 = California - TOLIC (eff. 1983)
        (term. 2000)
03070 = Connecticut General Life Insurance Co.
        (eff. 1983; term. 1985)
05130 = Idaho - Connecticut General (eff. 1983)
05320 = New Mexico - Equitable Insurance
        (eff. 1983; term. 1985)
05440 = Tennessee - Connecticut General (eff. 1983)
05530 = Wyoming - Equitable Insurance (eff. 1983)
        (term. 1989)
05535 = North Carolina - Connecticut General
        (eff. 1988)
05655 = DMERC-D - Connecticut General (eff. 1993)
10071 = Railroad Board Travelers (eff. 1983)
        (term. 2000)
10230 = Connecticut - Metra Health (eff. 1986)
        (term. 2000)
10240 = Minnesota - Metra Health (eff. 1983)
        (term. 2000)
10250 = Mississippi - Metra Health (eff. 1983)
        (term. 2000)
10490 = Virginia - Metra Health (eff. 1983)
        (term. 2000)
10555 = Travelers Insurance Co. (eff. 1993)
        (term. 2000)
11260 = Missouri - General American Life
        (eff. 1983; term. 1998)
14330 = New York - GHI (eff. 1983)
16360 = Ohio - Nationwide Insurance Co.
16510 = West Virginia - Nationwide Insurance Co.
21200 = Maine - BS of Massachusetts
```

```
                          31140 = California - National Heritage Ins.
                          31142 = Maine - National Heritage Ins.
                          31143 = Massachusetts - National Heritage Ins.
                          31144 = New Hampshire - National Heritage Ins.
                          31145 = Vermont - National Heritage Ins.
1         CARR_NUM_TB                        Carrier Number Table
          -----------                        --------------------

                          31146 = So. California - NHIC (eff. 2000)


1         CLM_BILL_TYPE_TB                   Claim Bill Type Table
          ----------------                   --------------------


                          11 = Hospital-inpatient (including Part A)
                          12 = Hospital-inpatient or home health visits (Part B only)
                          13 = Hospital-outpatient (HHA-A also) (under OPPS 13X
                               must be used for ASC claims submitted for OPPS
                               payment -- eff. 7/00)
                          14 = Hospital-other (Part B)
                          15 = Hospital-intermediate care - level I
                          16 = Hospital-intermediate care - level II
                          17 = Hospital-intermediate care - level III
                          18 = Hospital-swing beds
                          19 = Hospital-reserved for national assignment
                          21 = SNF-inpatient (including Part A)
                          22 = SNF-inpatient or home health visits (Part B only)
                          23 = SNF-outpatient (HHA-A also)
                          24 = SNF-other (Part B)
                          25 = SNF-intermediate care - level I
                          26 = SNF-intermediate care - level II
                          27 = SNF-intermediate care - level III
                          28 = SNF-swing beds
                          29 = SNF-reserved for national assignment
                          31 = HHA-inpatient (including Part A)
                          32 = HHA-inpatient or home health visits (Part B only)
                          33 = HHA-outpatient (HHA-A also)
                          34 = HHA-other (Part B)
                          35 = HHA-intermediate care - level I
                          36 = HHA-intermediate care - level II
                          37 = HHA-intermediate care - level III
                          38 = HHA-swing beds
                          39 = HHA-reserved for national assignment
                          41 = Religious Nonmedical Health Care Institution (RNHCI)
```

```
                    hospital-inpatient (including Part A) (all references
                    to Christian Science (CS) is obsolete eff. 8/00 and
                    replaced with RNHCI)
             42 = RNHCI hospital-inpatient or home health visits (Part B only)
             43 = RNHCI hospital-outpatient (HHA-A also)
             44 = RNHCI hospital-other (Part B)
             45 = RNHCI hospital-intermediate care - level I
             46 = RNHCI hospital-intermediate care - level II
             47 = RNHCI hospital-intermediate care - level III
             48 = RNHCI hospital-swing beds
             49 = RNHCI hospital-reserved for national assignment
             51 = CS extended care-inpatient (including Part A) OBSOLETE
                    eff. 7/00 - implementation of Religious Nonmedical
                    Health Care Institutions (RNHCI)
             52 = RNHCI extended care-inpatient or home health visits
                    (Part B only) (eff. 7/00); prior to 7/00 Christian Science (CS)
             53 = RNHCI extended care-outpatient (HHA-A also) (eff. 7/00);
                    prior to 7/00 referenced CS
             54 = RNHCI extended care-other (Part B)(eff. 7/00); prior
                    to 7/00 referenced CS
             55 = RNHCI extended care-intermediate care - level I (eff. 7/00)
                    prior to 7/00 referenced CS
             56 = RNHCI extended care-intermediate care - level II (eff. 7/00)
                    prior to 7/00 referenced CS
             57 = RNHCI extended care-intermediate care - level III (eff. 7/00)
                    prior to 7/00 referenced CS
             58 = RNHCI extended care-swing beds (eff. 7/00)
```

```
1       CLM_BILL_TYPE_TB                              Claim Bill Type Table
        ----------------                             --------------------
```

```
                    prior to 7/00 referenced CS
             59 = RNHCI extended care-reserved for national assignment
                    (eff. 7/00); prior to 7/00 referenced CS
             61 = Intermediate care-inpatient (including Part A)
             62 = Intermediate care-inpatient or home health visits (Part B only)
             63 = Intermediate care-outpatient (HHA-A also)
             64 = Intermediate care-other (Part B)
             65 = Intermediate care-intermediate care - level I
             66 = Intermediate care-intermediate care - level II
             67 = Intermediate care-intermediate care - level III
             68 = Intermediate care-swing beds
             69 = Intermediate care-reserved for national assignment
             71 = Clinic-rural health
             72 = Clinic-hospital based or independent renal dialysis facility
```

inpatientsnf.txt

73 = Clinic-independent provider based FQHC (eff 10/91)
74 = Clinic-ORF only (eff 4/97);
      ORF and CMHC (10/91 - 3/97)
75 = Clinic-CORF
76 = Clinic-CMHC (eff 4/97)
77 = Clinic-reserved for national assignment
78 = Clinic-reserved for national assignment
79 = Clinic-other
81 = Special facility or ASC surgery-hospice (non-hospital based)
82 = Special facility or ASC surgery-hospice (hospital based)
83 = Special facility or ASC surgery-ambulatory surgical center
      (Discontinued for Hospitals Subject to Outpatient PPS;
       hospitals must use 13X for ASC claims submitted for OPPS
       payment -- eff. 7/00)
84 = Special facility or ASC surgery-freestanding birthing center
85 = Special facility or ASC surgery-rural primary care hospital (eff
86 = Special facility or ASC surgery-reserved for national use
87 = Special facility or ASC surgery-reserved for national use
88 = Special facility or ASC surgery-reserved for national use
89 = Special facility or ASC surgery-other
91 = Reserved-inpatient (including Part A)
92 = Reserved-inpatient or home health visits (Part B only)
93 = Reserved-outpatient (HHA-A also)
94 = Reserved-other (Part B)
95 = Reserved-intermediate care - level I
96 = Reserved-intermediate care - level II
97 = Reserved-intermediate care - level III
98 = Reserved-swing beds
99 = Reserved-reserved for national assignment

1   CLM_DISP_TB   Claim Disposition Table
       -----------   -----------------------

01 = Debit accepted
02 = Debit accepted (automatic adjustment)
      applicable through 4/4/93
03 = Cancel accepted
61 = *Conversion code: debit accepted
62 = *Conversion code: debit accepted
       (automatic adjustment)
63 = *Conversion code: cancel accepted

   *Used only during conversion period:

```
1       CLM_FAC_TYPE_TB                         Claim Facility Type Table
        ---------------                         -------------------------


                          1 = Hospital
                          2 = Skilled nursing facility (SNF)
                          3 = Home health agency (HHA)
                          4 = Religious Nonmedical (Hospital)
                             (eff. 8/1/00); prior to 8/00 referenced Christian
                             Science (CS)
                          5 = Religious Nonmedical (Extended Care)
                             (eff. 8/1/00); prior to 8/00 referenced CS
                          6 = Intermediate care
                          7 = Clinic or hospital-based renal dialysis facility
                          8 = Special facility or ASC surgery
                          9 = Reserved


1       CLM_FREQ_TB                             Claim Frequency Table
        -----------                             ---------------------


                          0 = Non-payment/zero claims
                          1 = Admit thru discharge claim
                          2 = Interim - first claim
                          3 = Interim - continuing claim
                          4 = Interim - last claim
                          5 = Late charge(s) only claim
                          6 = Adjustment of prior claim
                          7 = Replacement of prior claim;
                             eff 10/93, provider debit
                          8 = Void/cancel prior claim.
                             eff 10/93, provider cancel
                          9 = Final claim -- used in an HH PPS
                             episode to indicate the claim
                             should be processed like debit/
                             credit adjustment to RAP (initial
                             claim) (eff. 10/00)
                          A = Admission notice - used when hospice
                             is submitting the HCFA-1450 as an
                             admission notice - hospice NOE only
                          B = Hospice termination/revocation notice
                             - hospice NOE only  (eff 9/93)
```

```
      C = Hospice change of provider notice
          - hospice NOE only (eff 9/93)
      D = Hospice election void/cancel
          - hospice NOE only  (eff 9/93)
      E = Hospice change of ownership
          - hospice NOE only  (eff 1/97)
      F = Beneficiary initiated adjustment
          (eff 10/93)
      G = CWF generated adjustment (eff 10/93)
      H = HCFA generated adjustment (eff 10/93)
      I = Misc adjustment claim (other than PRO
          or provider) - used to identify a
          debit adjustment initiated by HCFA or
          an intermediary - eff 10/93, used to
          identify intermediary initiated
          adjustment only
      J = Other adjustment request (eff 10/93)
      K = OIG initiated adjustment (eff 10/93)
      M = MSP adjustment (eff 10/93)
      P = Adjustment required by peer review
          organization (PRO)
      X = Special adjustment processing - used
          for QA editing (eff 8/92)
      Z = Hospital Encounter Data alternate sub-
          mission (TOB '11Z') used for MCO enrollee
          hospital discharges 7/1/97-12/31/98; not
          stored in NCH.  Exception:  Problem in
          startup months may have resulted in this
          abbreviated UB-92 being erroneously
          stored in NCH.
```

```
1      CLM_HHA_RFRL_TB                        Claim Home Health Referral Table
       ---------------                        --------------------------------


                    1 = Physician referral - The patient was
                        admitted upon the recommendation of
                        a personal physician.
                    2 = Clinic referral - The patient was
                        admitted upon the recommendation of
                        this facility's clinic physician.
                    3 = HMO referral - The patient was admitted
                        upon the recommendation of an health
                        maintenance organization (HMO)
```

```
                physician.
        4 = Transfer from hospital - The patient
            was admitted as an inpatient transfer
            from an acute care facility.
        5 = Transfer from a skilled nursing
            facility (SNF) - The patient was
            admitted as an inpatient transfer
            from a SNF.
        6 = Transfer from another health care
            facility - The patient was admitted
            as a transfer from a health care
            facility other than an acute care
            facility or SNF.
        7 = Emergency room - The patient was
            admitted upon the recommendation of
            this facility's emergency room
            physician.
        8 = Court/law enforcement - The patient was
            admitted upon the direction of a
            court of law or upon the request of
            a law enforcement agency's
            representative.
        9 = Information not available -  The means
            by which the patient was admitted is
            not known.
        A = Transfer from a Critical Access Hospital -
            patient was admitted/referred to this
            facility as a transfer from a Critical
            Access Hospital.
        B = Transfer from another HHA - Beneficiaries
            are permitted to transfer from one HHA
            to another unrelated HHA under HH PPS.
            (eff. 10/00)
        C = Readmission to same HHA - If a beneficiary
            is discharged from an HHA and then re-
            admitted within the original 60-day
            episode, the original episode must be
            closed early and a new once created.
            NOTE: the use of this code will permit
            the agency to send a new RAP allowing
            all claims to  be accepted by Medicare.
            (eff. 10/00)
```

1   CLM_HIPPS_TB   Claim SNF & HHA Health Insurance   PPS Table

------------   ---

******************* SNF PPS HIPPS **************************
***************1st 3 positions (RUGS-III group)***************
AAA = Default: No assessment

BA1,BA2,BB1,BB2 = Behavior only problems (e.g.,
                  physical/verbal abuse)

CA1,CA2,CB1,CB2 = Clinically-complex conditions
CC1,CC2   (e.g., chemo, dialysis)

IA1,IA2,IB1,IB2 = Impaired cognition (e.g., im-
                  paired cognition (e.g., short-
                  term memory)

PA1,PA2,PB1,PB2 = Reduced physical functions
PC1,PC2,PD1,PD2
PE1,PE2

RHA,RHB,RHC,RLA = Low/medium/high rehabilitation
RLB,RMA,RMB,RMC

RUA,RUB,RUC,RVA = Very high/ultra high rehabilita-
RVB,RVC   tion: highest level

SE1,SE2,SE3   = Extensive services; e.g.; IV feed
                  trach care

SSA,SSB,SSC   = Special care; e.g.; coma, burns

***********Positions 4 & 5 represent HIPPS modifier/********
*************** assessment type indicator ******************

00 = No assessment completed
01 = Medicare 5-day full assessment/not an initial
     admission assessment
02 = Medicare 30-day full assessment
03 = Medicare 60-day full assessment
04 = Medicare 90-day full assessment
05 = Medicare Readmission/Return required assessment
     (eff. 10/2000)
07 = Medicare 14-day full or comprehensive assessment/

```
                    not an initial admission assessment
           08 = Off-cycle Other Medicare Required Assessment (OMRA)
           11 = Admission assessment AND Medicare 5-day (or readmission/
                    return) assessment
           17 = Medicare 14-day required assessment AND initial
                    admission assessment (eff. 10/2000)
           18 = OMRA replacing Medicare 5-day required assessment
                    (eff. 10/2000)
           28 = OMRA replacing Medicare 30-day required assessment
                    (eff. 10/2000)
           30 = Off-cycle significant change assessment (outside
                    assessment window) (eff. 10/2000)
           31 = Significant change assessment replaces Medicare
                    5-day assessment (eff. 10/2000)
           32 = Significant change assessment replaces Medicare
                    30-day assessment
```

```
1        CLM_HIPPS_TB                 Claim SNF & HHA Health Insurance      PPS Table
         ------------                 --------------------------------------------------
```

```
           33 = Significant change assessment replaces Medicare
                    6--day assessment
           34 = Significant change assessment replaces Medicare
                    90-day assessment
           35 = Significant change assessment replaces a Medicare
                    readmission/return assessment
           37 = Significant change assessment replaces Medicare
                    14-day assessment
           38 = OMRA replacing Medicare 60-day required
                    assessment
           40 = Off-cycle significant correction assessment of a
                    prior assessment (outside assessment window)
                    (eff. 10/2000)
           41 = Significant correction of prior full assessment
                    replaces a Medicare 5-day assessment
           42 = Significant correction of prior full assessment
                    replaces a Medicare 30-day assessment
           43 = Significant correction of prior full assessment
                    replaces a Medicare 60-day assessment
           44 = Significant correction of prior full assessment
                    replaces a Medicare 90-day assessment
           45 = Significant correction of a prior assessment
                    replaces a readmission/return assessment
                    (eff. 10/2000)
           47 = Significant correction of prior full assessment
```

```
                            inpatientsnf.txt
                  replaces a Medicare 14-day required assessment
            48 = OMRA replacing Medicare 90-day required assessment
            54 = Quarterly review assessment - Medicare 90-day
                  full assessment
            78 = OMRA replacing a Medicare 14-day assessment
                  (eff. 10/2000)


            ****************************************************************
            ****************************************************************



            *************Claim Home Health PPS HIPPS Table****************
            *********************** KEY ********************************
            Position 1 = 'H'
            Position 2 = Clinical (A, B, C, D)
            Position 3 = Functional (E, F, G, H, I)
            Position 4 = Service (J, K, K, M)
            Position 5 = identifies which elements of the code were
                           computed or derived:
                           1 = 2nd, 3rd, 4th positions computed
                           2 = 2nd position derived
                           3 = 3rd position derived
                           4 = 4th position derived
                           5 = 2nd & 3rd positions derived
                           6 = 3rd & 4th positions derived
                           7 = 2nd & 4th positions derived
                           8 = 2nd, 3rd, 4th positions derived
            ****************************************************************

            **HHRG = C0F0S0/Clinical = Min, Functional = Min, Service = Min**
            HAEJ1
            HAEJ2
            HAEJ3
```
1	CLM_HIPPS_TB	Claim SNF & HHA Health Insurance PPS Table
	------------	---

```
            HAEJ4
            HAEJ5
            HAEJ6
            HAEJ7
            HAEJ8
            **HHRG = C0F0S1/Clinical = Min, Functional = Min, Service = Low**
            HAEK1
            HAEK2
```

```
HAEK3
HAEK4
HAEK5
HAEK6
HAEK7
HAEK8
**HHRG = C0F0S2/Clinical = Min, Functional = Min, Service = Mod**
HAEL1
HAEL2
HAEL3
HAEL4
HAEL5
HAEL6
HAEL7
HAEL8
**HHRG = C0F0S3/Clinical = Min, Functional = Min, Service = High**
HAEM1
HAEM2
HAEM3
HAEM4
HAEM5
HAEM6
HAEM7
HAEM8
**HHRG = C0F1S0/Clinical = Min, Functional = Low, Service = Min**
HAFJ1
HAFJ2
HAFJ3
HAFJ4
HAFJ5
HAFJ6
HAFJ7
HAFJ8
**HHRG = C0F1S1/Clinical = Min, Functional = Low, Service = Low**
HAFK1
HAFK2
HAFK3
HAFK4
HAFK5
HAFK6
HAFK7
HAFK8
**HHRG = C0F1S2/Clinical = Min, Functional = Low, Service = Mod**
HAFL1
```

```
                                            HAFL2
                                            HAFL3
                                            HAFL4
                                            HAFL5
                                            HAFL6
                                            HAFL7
1          CLM_HIPPS_TB                 Claim SNF & HHA Health Insurance        PPS Table
           ------------                 --------------------------------------------------

                                            HAFL8
                                            **HHRG = C0F1S3/Clinical = Min, Functional = Low, Service = High**
                                            HAFM1
                                            HAFM2
                                            HAFM3
                                            HAFM4
                                            HAFM5
                                            HAFM6
                                            HAFM7
                                            HAFM8
                                            **HHRG = C0F2S0/Clinical = Min, Functional = Mod, Service = Min**
                                            HAGJ1
                                            HAGJ2
                                            HAGJ3
                                            HAGJ4
                                            HAGJ5
                                            HAGJ6
                                            HAGJ7
                                            HAGJ8
                                            **HHRG = C0F2S1/Clinical = Min, Functional = Mod, Service = Low**
                                            HAGK1
                                            HAGK2
                                            HAGK3
                                            HAGK4
                                            HAGK5
                                            HAGK6
                                            HAGK7
                                            HAGK8
                                            **HHRG = C0F2S2/Clinical = Min, Functional = Mod, Service = Mod**
                                            HAGL1
                                            HAGL2
                                            HAGL3
                                            HAGL4
                                            HAGL5
                                            HAGL6
```

```
                                HAGL7
                                HAGL8
                                **HHRG = C0F2S3/Clinical = Min, Functional = Mod, Service = High**
                                HAGM1
                                HAGM2
                                HAGM3
                                HAGM4
                                HAGM5
                                HAGM6
                                HAGM7
                                HAGM8
                                **HHRG = C0F3S0/Clinical = Min, Functional = High, Service = Min**
                                HAHJ1
                                HAHJ2
                                HAHJ3
                                HAHJ4
                                HAHJ5
                                HAHJ6
                                HAHJ7
                                HAHJ8
                                **HHRG = C0F3S1/Clinical = Min, Functional = High, Service = Low**
                                HAHK1
                                HAHK2
```

```
1         CLM_HIPPS_TB                Claim SNF & HHA Health Insurance      PPS Table
          ------------                --------------------------------------------------
```

```
                                HAHK3
                                HAHK4
                                HAHK5
                                HAHK6
                                HAHK7
                                HAHK8
                                **HHRG = C0F3S2/Clinical = Min, Functional = High, Service = Mod**
                                HAHL1
                                HAHL2
                                HAHL3
                                HAHL4
                                HAHL5
                                HAHL6
                                HAHL7
                                HAHL8
                                **HHRG = C0F3S3/Clinical = Min, Functional = High, Service = High**
                                HAHM1
                                HAHM2
```

```
                            HAHM3
                            HAHM4
                            HAHM5
                            HAHM6
                            HAHM7
                            HAHM8
                            **HHRG = C0F4S0/Clinical = Min, Functional = Max, Service = Min**
                            HAIJ1
                            HAIJ2
                            HAIJ3
                            HAIJ4
                            HAIJ5
                            HAIJ6
                            HAIJ7
                            HAIJ8
                            **HHRG = C0F4S1/Clinical = Min, Functional = Max, Service = Low**
                            HAIK1
                            HAIK2
                            HAIK3
                            HAIK4
                            HAIK5
                            HAIK6
                            HAIK7
                            HAIK8
                            **HHRG = C0F4S2/Clinical = Min, Functional = Max, Service = Mod**
                            HAIL1
                            HAIL2
                            HAIL3
                            HAIL4
                            HAIL5
                            HAIL6
                            HAIL7
                            HAIL8
                            **HHRG = C0F4S3/Clinical = Min, Functional = Max, Service = High**
                            HAIM1
                            HAIM2
                            HAIM3
                            HAIM4
                            HAIM5
                            HAIM6
1      CLM_HIPPS_TB                Claim SNF & HHA Health Insurance      PPS Table
       ------------                --------------------------------------------------

                            HAIM7
```

```
HAIM8
**HHRG = C1F0S0/Clinical = Low, Functional = Min, Service = Min**
HBEJ1
HBEJ2
HBEJ3
HBEJ4
HBEJ5
HBEJ6
HBEJ7
HBEJ8
**HHRG = C1F0S1/Clinical = Low, Functional = Min, Service = Low**
HBEK1
HBEK2
HBEK3
HBEK4
HBEK5
HBEK6
HBEK7
HBEK8
**HHRG = C1F0S2/Clinical = Low, Functional = Min, Service = Mod**
HBEL1
HBEL2
HBEL3
HBEL4
HBEL5
HBEL6
HBEL7
HBEL8
**HHRG = C1F0S3/Clinical = Low, Functional = Min, Service = High**
HBEM1
HBEM2
HBEM3
HBEM4
HBEM5
HBEM6
HBEM7
HBEM8
**HHRG = C1F1S0/Clinical = Low, Functional = Low, Service = Min**
HBFJ1
HBFJ2
HBFJ3
HBFJ4
HBFJ5
HBFJ6
```

```
                        HBFJ7
                        HBFJ8
                        **HHRG = C1F1S1/Clinical = Low, Functional = Low, Service = Low**
                        HBFK1
                        HBFK2
                        HBFK3
                        HBFK4
                        HBFK5
                        HBFK6
                        HBFK7
                        HBFK8
                        **HHRG = C1F1S2/Clinical = Low, Functional = Low, Service = Mod**
                        HBFL1
1        CLM_HIPPS_TB            Claim SNF & HHA Health Insurance        PPS Table
         ------------            --------------------------------------------------

                        HBFL2
                        HBFL3
                        HBFL4
                        HBFL5
                        HBFL6
                        HBFL7
                        HBFL8
                        **HHRG = C1F1S3/Clinical = Low, Functional = Low, Service = High**
                        HBFM1
                        HBFM2
                        HBFM3
                        HBFM4
                        HBFM5
                        HBFM6
                        HBFM7
                        HBFM8
                        **HHRG = C1F2S0/Clinical = Low, Functional = Mod, Service = Min**
                        HBGJ1
                        HBGJ2
                        HBGJ3
                        HBGJ4
                        HBGJ5
                        HBGJ6
                        HBGJ7
                        HBGJ8
                        **HHRG = C1F2S1/Clinical = Low, Functional = Mod, Service = Low**
                        HBGK1
                        HBGK2
```

```
                           HBGK3
                           HBGK4
                           HBGK5
                           HBGK6
                           HBGK7
                           HBGK8
                           **HHRG = C1F2S2/Clinical = Low, Functional = Mod, Service = Mod**
                           HBGL1
                           HBGL2
                           HBGL3
                           HBGL4
                           HBGL5
                           HBGL6
                           HBGL7
                           HBGL8
                           **HHRG = C1F2S3/Clinical = Low, Functional = Mod, Service = High**
                           HBGM1
                           HBGM2
                           HBGM3
                           HBGM4
                           HBGM5
                           HBGM6
                           HBGM7
                           HBGM8
                           **HHRG = C1F3S0/Clinical = Low, Functional = High, Service = Min**
                           HBHJ1
                           HBHJ2
                           HBHJ3
                           HBHJ4
                           HBHJ5
  1        CLM_HIPPS_TB                 Claim SNF & HHA Health Insurance       PPS Table
           ------------                 --------------------------------------------------

                           HBHJ6
                           HBHJ7
                           HBHJ8
                           **HHRG = C1F3S1/Clinical = Low, Functional = High, Service = Low**
                           HBHK1
                           HBHK2
                           HBHK3
                           HBHK4
                           HBHK5
                           HBHK6
                           HBHK7
```

HBHK8
HHRG = C1F3S2/Clinical = Low, Functional = High, Service = Mod
HBHL1
HBHL2
HBHL3
HBHL4
HBHL5
HBHL6
HBHL7
HBHL8
HHRG = C1F3S3/Clinical = Low, Functional = High, Service = High
HBHM1
HBHM2
HBHM3
HBHM4
HBHM5
HBHM6
HBHM7
HBHM8
HHRG = C1F4S0/Clinical = Low, Functional = Max, Service = Min
HBIJ1
HBIJ2
HBIJ3
HBIJ4
HBIJ5
HBIJ6
HBIJ7
HBIJ8
HHRG = C1F4S1/Clinical = Low, Functional = Max, Service = Low
HBIK1
HBIK2
HBIK3
HBIK4
HBIK5
HBIK6
HBIK7
HBIK8
HHRG = C1F4S2/Clinical = Low, Functional = Max, Service = Mod
HBIL1
HBIL2
HBIL3
HBIL4
HBIL5
HBIL6

```
                                     HBIL7
                                     HBIL8
                                     **HHRG = C1F4S3/Clinical = Low, Functional = Max, Service = High**
1           CLM_HIPPS_TB                     Claim SNF & HHA Health Insurance      PPS Table
            ------------                     -------------------------------------------------

                                     HBIM1
                                     HBIM2
                                     HBIM3
                                     HBIM4
                                     HBIM5
                                     HBIM6
                                     HBIM7
                                     HBIM8
                                     **HHRG = C2F0S0/Clinical = Mod, Functional = Min, Service = Min**
                                     HCEJ1
                                     HCEJ2
                                     HCEJ3
                                     HCEJ4
                                     HCEJ5
                                     HCEJ6
                                     HCEJ7
                                     HCEJ8
                                     **HHRG = C2F0S1/Clinical = Mod, Functional = Min, Service = Low**
                                     HCEK1
                                     HCEK2
                                     HCEK3
                                     HCEK4
                                     HCEK5
                                     HCEK6
                                     HCEK7
                                     HCEK8
                                     **HHRG = C2F0S2/Clinical = Mod, Functional = Min, Service = Mod**
                                     HCEL1
                                     HCEL2
                                     HCEL3
                                     HCEL4
                                     HCEL5
                                     HCEL6
                                     HCEL7
                                     HCEL8
                                     **HHRG = C2F0S3/Clinical = Mod, Functional = Min, Service = High**
                                     HCEM1
                                     HCEM2
```

```
                        HCEM3
                        HCEM4
                        HCEM5
                        HCEM6
                        HCEM7
                        HCEM8
                        **HHRG = C2F1S0/Clinical = Mod, Functional = Low, Service = Min**
                        HCFJ1
                        HCFJ2
                        HCFJ3
                        HCFJ4
                        HCFJ5
                        HCFJ6
                        HCFJ7
                        HCFJ8
                        **HHRG = C2F1S2/Clinical = Mod, Functional = Low, Service = Mod**
                        HCFL1
                        HCFL2
                        HCFL3
                        HCFL4
1       CLM_HIPPS_TB              Claim SNF & HHA Health Insurance      PPS Table
        ------------              --------------------------------------------------

                        HCFL5
                        HCFL6
                        HCFL7
                        HCFL8
                        **HHRG = C2F1S3/Clinical = Mod, Functional = Low, Service = High**
                        HCFM1
                        HCFM2
                        HCFM3
                        HCFM4
                        HCFM5
                        HCFM6
                        HCFM7
                        HCFM8
                        **HHRG = C2F2S0/Clinical = Mod, Functional = Mod, Service = Min**
                        HCGJ1
                        HCGJ2
                        HCGJ3
                        HCGJ4
                        HCGJ5
                        HCGJ6
                        HCGJ7
```

```
                                HCGJ8
                                **HHRG = C2F2S1/Clinical = Mod, Functional = Mod, Service = Low**
                                HCGK1
                                HCGK2
                                HCGK3
                                HCGK4
                                HCGK5
                                HCGK6
                                HCGK7
                                HCGK8
                                **HHRG = C2F2S2/Clinical = Mod, Functional = Mod, Service = Mod**
                                HCGL1
                                HCGL2
                                HCGL3
                                HCGL4
                                HCGL5
                                HCGL6
                                HCGL7
                                HCGL8
                                **HHRG = C2F2S3/Clinical = Mod, Functional = Mod, Service = High**
                                HCGM1
                                HCGM2
                                HCGM3
                                HCGM4
                                HCGM5
                                HCGM6
                                HCGM7
                                HCGM8
                                **HHRG = C2F3S0/Clinical = Mod, Functional = High, Service = Min**
                                HCHJ1
                                HCHJ2
                                HCHJ3
                                HCHJ4
                                HCHJ5
                                HCHJ6
                                HCHJ7
                                HCHJ8
```

```
1       CLM_HIPPS_TB                  Claim SNF & HHA Health Insurance      PPS Table
        ------------                  -----------------------------------------------

                                **HHRG = C2F3S1/Clinical = Mod, Functional = High, Service = Low**
                                HCHK1
                                HCHK2
                                HCHK3
```

HCHK4
HCHK5
HCHK6
HCHK7
HCHK8
HHRG = C2F3S2/Clinical = Mod, Functional = High, Service = Mod
HCHL1
HCHL2
HCHL3
HCHL4
HCHL5
HCHL6
HCHL7
HCHL8
HHRG = C2F3S3/Clinical = Mod, Functional = High, Service = High
HCHM1
HCHM2
HCHM3
HCHM4
HCHM5
HCHM6
HCHM7
HCHM8
HHRG = C2F4S0/Clinical = Mod, Functional = Max, Service = Min
HCIJ1
HCIJ2
HCIJ3
HCIJ4
HCIJ5
HCIJ6
HCIJ7
HCIJ8
HHRG = C2F4S1/Clinical = Mod, Functional = Max, Service = Low
HCIK1
HCIK2
HCIK3
HCIK4
HCIK5
HCIK6
HCIK7
HCIK8
HHRG = C2F4S2/Clinical = Mod, Functional = Max, Service = Mod
HCIL1
HCIL2

```
                                    HCIL3
                                    HCIL4
                                    HCIL5
                                    HCIL6
                                    HCIL7
                                    HCIL8
                                    **HHRG = C2F4S3/Clinical = Mod, Functional = Max, Service = High**
                                    HCIM1
                                    HCIM2
                                    HCIM3
1          CLM_HIPPS_TB                      Claim SNF & HHA Health Insurance        PPS Table
           ------------                      ------------------------------------------------

                                    HCIM4
                                    HCIM5
                                    HCIM6
                                    HCIM7
                                    HCIM8
                                    **HHRG = C3F0S0/Clinical = High, Functional = Min, Service = Min**
                                    HDEJ1
                                    HDEJ2
                                    HDEJ3
                                    HDEJ4
                                    HDEJ5
                                    HDEJ6
                                    HDEJ7
                                    HDEJ8
                                    **HHRG = C3F0S1/Clinical = High, Functional = Min, Service = Low**
                                    HDEK1
                                    HDEK2
                                    HDEK3
                                    HDEK4
                                    HDEK5
                                    HDEK6
                                    HDEK7
                                    HDEK8
                                    **HHRG = C3F0S2/Clinical = High, Functional = Min, Service = Mod**
                                    HDEL1
                                    HDEL2
                                    HDEL3
                                    HDEL4
                                    HDEL5
                                    HDEL6
                                    HDEL7
```

```
                          HDEL8
                          **HHRG = C3F0S3/Clinical = High, Functional = Min, Service = High**
                          HDEM1
                          HDEM2
                          HDEM3
                          HDEM4
                          HDEM5
                          HDEM6
                          HDEM7
                          HDEM8
                          **HHRG = C3F1S0/Clinical = High, Functional = Low, Service = Min**
                          HDFJ1
                          HDFJ2
                          HDFJ3
                          HDFJ4
                          HDFJ5
                          HDFJ6
                          HDFJ7
                          HDFJ8
                          **HHRG = C3F1S1/Clinical = High, Functional = Low, Service = Low**
                          HDFK1
                          HDFK2
                          HDFK3
                          HDFK4
                          HDFK5
                          HDFK6
                          HDFK7
1         CLM_HIPPS_TB              Claim SNF & HHA Health Insurance      PPS Table
          ------------              ---------------------------------------------------

                          HDFK8
                          **HHRG = C3F1S2/Clinical = High, Functional = Low, Service = Mod**
                          HDFL1
                          HDFL2
                          HDFL3
                          HDFL4
                          HDFL5
                          HDFL6
                          HDFL7
                          HDFL8
                          **HHRG = C3F1S3/Clinical = High, Functional = Low, Service = High**
                          HDFM1
                          HDFM2
                          HDFM3
```

```
HDFM4
HDFM5
HDFM6
HDFM7
HDFM8
**HHRG = C3F2S0/Clinical = High, Functional = Mod, Service = Min**
HDGJ1
HDGJ2
HDGJ3
HDGJ4
HDGJ5
HDGJ6
HDGJ7
HDGJ8
**HHRG = C3F2S1/Clinical = High, Functional = Mod, Service = Low**
HDGK1
HDGK2
HDGK3
HDGK4
HDGK5
HDGK6
HDGK7
HDGK8
**HHRG = C3F2S2/Clinical = High, Functional = Mod, Service = Mod**
HDGL1
HDGL2
HDGL3
HDGL4
HDGL5
HDGL6
HDGL7
HDGL8
**HHRG = C3F2S3/Clinical = High, Functional = Mod, Service = High**
HDGM1
HDGM2
HDGM3
HDGM4
HDGM5
HDGM6
HDGM7
HDGM8
**HHRG = C3F3S0/Clinical = High, Functional = High, Service = Min**
HDHJ1
HDHJ2
```

1   CLM_HIPPS_TB   Claim SNF & HHA Health Insurance   PPS Table
           ------------   ---
                                               HDHJ3
                                               HDHJ4
                                               HDHJ5
                                               HDHJ6
                                               HDHJ7
                                               HDHJ8
                                               HHRG = C3F3S1/Clinical = High, Functional = High, Service = Low
                                               HDHK1
                                               HDHK2
                                               HDHK3
                                               HDHK4
                                               HDHK5
                                               HDHK6
                                               HDHK7
                                               HDHK8
                                               HHRG = C3F3S2/Clinical = High, Functional = High, Service = Mod
                                               HDHL1
                                               HDHL2
                                               HDHL3
                                               HDHL4
                                               HDHL5
                                               HDHL6
                                               HDHL7
                                               HDHL8
                                               HHRG = C3F3S3/Clinical = High, Functional = High, Service = High
                                               HDHM1
                                               HDHM2
                                               HDHM3
                                               HDHM4
                                               HDHM5
                                               HDHM6
                                               HDHM7
                                               HDHM8
                                               HHRG = C3F4S0/Clinical = High, Functional = Max, Service = Min
                                               HDIJ1
                                               HDIJ2
                                               HDIJ3
                                               HDIJ4
                                               HDIJ5
                                               HDIJ6
                                               HDIJ7

```
                         HDIJ8
                         **HHRG = C3F4S1/Clinical = High, Functional = Max, Service = Low**
                         HDIK1
                         HDIK2
                         HDIK3
                         HDIK4
                         HDIK5
                         HDIK6
                         HDIK7
                         HDIK8
                         **HHRG = C3F4S2/Clinical = High, Functional = Max, Service = Mod**
                         HDIL1
                         HDIL2
                         HDIL3
                         HDIL4
                         HDIL5
                         HDIL6
1        CLM_HIPPS_TB                   Claim SNF & HHA Health Insurance       PPS Table
         ------------                   -------------------------------------------------

                         HDIL7
                         HDIL8
                         **HHRG = C3F4S3/Clinical = High, Functional = Max, Service = High**
                         HDIM1
                         HDIM2
                         HDIM3
                         HDIM4
                         HDIM5
                         HDIM6
                         HDIM7
                         HDIM8


1    CLM_IP_ADMSN_TYPE_TB                        Claim Inpatient Admission Type Table
     --------------------                        ------------------------------------


                         0 = Blank
                         1 = Emergency - The patient required
                             immediate medical intervention as a
                             result of severe, life threatening, or
                             potentially disabling conditions.
                             Generally, the patient was admitted
                             through the emergency room.
                         2 = Urgent - The patient required immediate
```

```
                        attention for the care and treatment
                        of a physical or mental disorder.
                        Generally, the patient was admitted to
                        the first available and suitable
                        accommodation.
                    3 = Elective - The patient's condition
                        permitted adequate time to schedule the
                        availability of suitable accommodations.
                    4 = Newborn - Necessitates the use of
                        special source of admission codes.

                    5 THRU 8 =  Reserved.
                    9 =  Unknown - Information not available.
```

1   CLM_MDCR_NPMT_RSN_TB   Claim Medicare Non-Payment Reason Table
     --------------------   ---------------------------------------


```
                    A = Covered worker's compensation (Obsolete)
                    B = Benefit exhausted
                    C = Custodial care - noncovered care
                        (includes all 'beneficiary at fault'
                        waiver cases) (Obsolete)
                    E = HMO out-of-plan services not emergency
                        or urgently needed (Obsolete)
                    E = MSP cost avoided - IRS/SSA/HCFA Data
                        Match (eff. 7/00)
                    F = MSP cost avoid HMO Rate Cell (eff. 7/00)
                    G = MSP cost avoided Litigation Settlement
                        (eff. 7/00)
                    H = MSP cost avoided Employer Voluntary
                        Reporting (eff. 7/00)
                    J = MSP cost avoid Insurer Voluntary
                        Reporting (eff. 7/00)
                    K = MSP cost avoid Initial Enrollment
                        Questionnaire (eff. 7/00)
                    N = All other reasons for nonpayment
                    P = Payment requested
                    Q = MSP cost avoided Voluntary Agreement
                        (eff. 7/00)
                    R = Benefits refused, or evidence not
                        submitted
                    T = MSP cost avoided - IEQ contractor
                        (eff. 9/76) (obsolete 6/30/00)
```

```
          U = MSP cost avoided - HMO rate cell
              adjustment (eff. 9/76) (Obsolete 6/30/00)
          V = MSP cost avoided - litigation
              settlement (eff. 9/76) (Obsolete 6/30/00)
          W = Worker's compensation (Obsolete)
          X = MSP cost avoided - generic
          Y = MSP cost avoided - IRS/SSA data
              match project (obsolete 6/30/00)
          Z = Zero reimbursement RAPs -- zero reimbursement
              made due to medical review intervention or
              where provider specific zero payment has been
              determined. (effective with HHPPS - 10/00)
```

1   CLM_OCRNC_SPAN_TB   Claim Occurrence Span Table
       ------------------   ---------------------------


```
          70 = Eff 10/93, payer use only, the
               nonutilization from/thru dates
               for PPS-inlier stay where bene had
               exhausted all full/coinsurance days, but
               covered on cost report.
               SNF qualifying hospital stay from/thru dates
          71 = Hospital prior stay dates - the from/
               thru dates of any hospital stay that
               ended within 60 days of this hospital
               or SNF admission.
          72 = First/last visit - the dates of the
               first and last visits occurring in this
               billing period if the dates are different
               from those in the statement covers period.
          73 = Benefit eligibility period - the
               inclusive dates during which CHAMPUS
               medical benefits are available to a
               sponsor's bene as shown on the
               bene's ID card.
          74 = Non-covered level of care - The from/
               thru dates of a period at a noncovered
               level of care in an otherwise
               covered stay, excluding any period
               reported with occurrence span code 76,
               77, or 79.
          75 = The from/thru dates of SNF level of care
               during IP hospital stay.  Shows PRO approval
```

```
                        of patient remaining in hospital
                        because SNF bed not available.
                        not applicable to swing bed
                        cases. PPS hospitals use in day
                        outlier cases only.
                76 = Patient liability - From/thru
                        dates of period of noncovered care
                        for which hospital may charge
                        bene. The FI or PRO must have
                        approved such charges in advance.
                        patient must be notified in writing
                        3 days prior to noncovered period
                77 = Provider liability - The from/thru
                        dates of period of noncovered care
                        for which the provider is liable.
                        Eff 3/92, applies to provider liability
                        where bene is charged with utilization
                        and is liable for deductible/coinsurance
                78 = SNF prior stay dates - The from/
                        thru dates of any SNF stay that
                        ended within 60 days of this hospital
                        or SNF admission.
                79 = (Payer code) -
                        Eff 3/92, from/thru dates of
                        period of noncovered care where
                        bene is not charged with utilization,
                        deductible, or coinsurance.
                        and provider is liable.
                        Eff 9/93, noncovered period of care
                        due to lack of medical necessity.
1       CLM_OCRNC_SPAN_TB                        Claim Occurrence Span Table
        -----------------                        ---------------------------

                80 - 99 = Reserved for state assignment
                M0 = PRO/UR approved stay dates - Eff 10/93,
                        the first and last days that were
                        approved where not all of the stay was
                        approved.

1       CLM_PPS_IND_TB                           Claim PPS Indicator Table
        --------------                           -------------------------
```

Effective NCH weekly process date 10/3/97 - 5/29/98

```
              0 = not PPS bill (claim contains no PPS indicator)
              2 = PPS bill ( claim contains PPS indicator)

              ***Effective NCH weekly process date 6/5/98***

              0 = not applicable (claim contains neither PPS
                  nor deemed insured MQGE status indicators)
              1 = Deemed insured MQGE (claim contains deemed
                  insured MQGE indicator but not PPS indicator)
              2 = PPS bill ( claim contains PPS indicator but no
                  deemed insured MQGE status indicator)
              3 = Both PPS and deemed insured MQGE (contains both
                  PPS and deemed insured MQGE indicators)
```

1   CLM_RLT_COND_TB   Claim Related Condition Table
       ---------------   -----------------------------


```
              01 = Military service related - Medical
                   condition incurred during military
                   service.
              02 = Employment related - Patient alleged
                   that the medical condition causing this
                   episode of care was due to environment/
                   events resulting from employment.
              03 = Patient covered by insurance not
                   reflected here - Indicates that patient
                   or patient representative has stated
                   that coverage may exist beyond that
                   reflected on this bill.
              04 = Health Maintenance Organization (HMO)
                   enrollee - Medicare beneficiary is
                   enrolled in an HMO.  Eff 9/93, hospital
                   must also expect to receive payment
                   from HMO.
              05 = Lien has been filed - Provider has
                   filed legal claim for recovery of funds
                   potentially due a patient as a result
                   of legal action initiated by or on
                   behalf of the patient.
              06 = ESRD patient in 1st 18 months of entitlement
                   covered by employer group health insurance -
                   indicates Medicare may be secondary
```

```
                       insurer.  Eff 3/1/96, ESRD patient in 1st
                       30 months of entitlement covered by employer
                       group health insurance.
             07 = Treatment of nonterminal condition for
                       hospice patient - The patient is a
                       hospice enrollee, but the provider is
                       not treating a terminal condition and
                       is requesting Medicare reimbursement.
             08 = Beneficiary would not provide information
                       concerning other insurance coverage.
             09 = Neither patient nor spouse is employed
                       - Code indicates that in response to
                       development questions, the patient and
                       spouse have denied employment.
             10 = Patient and/or spouse is employed but
                       no EGHP coverage exists or (eff 9/93)
                       other employer sponsored/provided
                       health insurance covering patient.
             11 = The disabled beneficiary and/or family
                       member has no group coverage from a LGHP
                       or (eff 9/93) other employer
                       sponsored/provided health insurance
                       covering patient.
             12 = Payer code - Reserved for internal
                       use only by third party payers.  HCFA
                       will assign as needed.  Providers will
                       not report them.
             13 = Payer code - Reserved for internal
                       use only by third party payers.  HCFA
                       will assign as needed.  Providers will
                       not report them.
             14 = Payer code - Reserved for internal
```

```
1       CLM_RLT_COND_TB                        Claim Related Condition Table
        ---------------                        ----------------------------
```

```
                       use only by third party payers.  HCFA
                       will assign as needed.  Providers will
                       not report them.
             15 = Clean claim (eff 10/92)
             16 = SNF transition exemption - An
                       exemption from the post-hospital
                       requirement applies for this SNF stay
                       or the qualifying stay dates are more
                       than 30 days prior to the admission date
```

17 = Patient is over 100 years old - Code
     indicates that the patient was over
     100 years old at the date of admission.

18 = Maiden name retained - A dependent
     spouse entitled to benefits who does
     not use her husband's last name.

19 = Child retains mother's name - A
     patient who is a dependent child
     entitled to CHAMPVA benefits that does
     not have father's last name.

20 = Bene requested billing - Provider
     realizes the services on this bill are at a
     noncovered level of care or otherwise excluded
     from coverage, but the bene has requested
     formal determination

21 = Billing for denial notice - The SNF or HHA
     realizes services are at a noncovered level of
     care or excluded, but requests a Medicare denial
     in order to bill medicaid or other insurer

22 = Patient on multiple drug regimen - A
     patient who is receiving multiple
     intravenous drugs while on home IV
     therapy

23 = Homecaregiver available - The patient
     has a caregiver available to assist him
     or her during self-administration of an
     intravenous drug

24 = Home IV patient also receiving HHA
     services - the patient is under care
     of HHA while receiving home IV drug
     therapy services

25 = Reserved for national assignment

26 = VA eligible patient chooses to
     receive services in Medicare certified
     facility rather than a VA facility
     (eff 3/92)

27 = Patient referred to a sole community
     hospital for a diagnostic laboratory
     test - (sole community hospital only).
     (eff 9/93)

28 = Patient and/or spouse's EGHP is
     secondary to Medicare -
     Qualifying EGHP for employers who have
     fewer than 20 employees. (eff 9/93)

```
                                  29 = Disabled beneficiary and/or family
                                       member's LGHP is secondary to
                                       Medicare - Qualifying LGHP for
                                       employer having fewer than 100 full and
                                       part-time employees
1       CLM_RLT_COND_TB                        Claim Related Condition Table
        ---------------                        ----------------------------

                                  31 = Patient is student (full time - day) -
                                       Patient declares that he or she is
                                       enrolled as a full time day student.
                                  32 = Patient is student (cooperative/work
                                       study program)
                                  33 = Patient is student (full time - night)
                                       - Patient declares that he or she is
                                       enrolled as a full time night student.
                                  34 = Patient is student (part time) -
                                       Patient declares that he or she is
                                       enrolled as a part time student.
                                  36 = General care patient in a special
                                       unit - Patient is temporarily placed in
                                       special care unit bed because no
                                       general care beds were available.
                                  37 = Ward accommodation is patient's
                                       request - Patient is assigned to ward
                                       accommodations at patient's request.
                                  38 = Semi-private room not available -
                                       Indicates that either private or ward
                                       accommodations were assigned because
                                       semi-private accomodations were not
                                       available.
                                  39 = Private room medically necessary -
                                       Patient needed a private room for
                                       medical reasons.
                                  40 = Same day transfer - Patient
                                       transferred to another facility
                                       before midnight of the day of admission.
                                  41 = Partial hospitalization - Eff 3/92,
                                       indicates claim is for partial
                                       hospitalization services.  For OP
                                       services, this includes a variety
                                       of psych programs.
                                  42 = Reserved for national assignment.
                                  43 = Reserved for national assignment.
```

```
                        44 = Reserved for national assignment.
                        45 = Reserved for national assignment.
                        46 = Nonavailability statement on file for
                             CHAMPUS claim for nonemergency IP care
                             for CHAMPUS bene residing within the
                             catchment area (usually a 40 mile
                             radius) of a uniform services hospital.
                        47 = Reserved for CHAMPUS.
                        48 = Reserved for national assignment.
                        49 = Reserved for national assignment.
                        50 = Reserved for national assignment.
                        51 = Reserved for national assignment.
                        52 = Reserved for national assignment.
                        53 = Reserved for national assignment.
                        54 = Reserved for national assignment.
                        55 = SNF bed not available - The patient's
                             SNF admission was delayed more than 30
                             days after hospital discharge because
                             a SNF bed was not available.
                        56 = Medical appropriateness - Patient's
                             SNF admission was delayed more than 30
                             days after hospital discharge because
```

```
1      CLM_RLT_COND_TB                           Claim Related Condition Table
       ----------------                          -----------------------------
```

```
                             physical condition made it inappropriate
                             to begin active care within that period
                        57 = SNF readmission - Patient previously
                             received Medicare covered SNF care
                             within 30 days of the current SNF
                             admission.
                        58 = Payment of SNF claims for beneficiaries
                             disenrolling from terminating M+C plans
                             plans who have not met the 3-day hospital
                             stay requirement (eff. 10/1/00)
                        59 = Reserved for national assignment.
                        60 = Operating cost day outlier - PRICER
                             indicates this bill is length of stay
                             outlier (PPS)
                        61 = Operating cost cost outlier - PRICER
                             indicates this bill is a cost outlier
                             (PPS)
                        62 = PIP bill - This bill is a periodic
                             interim payment bill.
```

```
63 = PRO denial received before batch
     clearance report - The HCSSACL receipt date
     is used on PRO adjustment if the PRO's
     notification is before orig bill's acceptance
     report. (Payer only code eff 9/93)
64 = Other than clean claim - The claim is
     not a 'clean claim'
65 = Non-PPS code - The bill is not a
     prospective payment system bill.
66 = Outlier not claimed - Bill may meet
     the criteria for cost outlier, but the
     hospital did not claim the cost outlier
     (PPS)
67 = Beneficiary elects not to use LTR days
68 = Beneficiary elects to use LTR days
69 = Operating IME Payment Only - providers
     request for IME payment for each discharge
     of MCO enrollee, beginning 1/1/98, from
     teaching hospitals (facilities with approved
     medical residency training program); not
     stored in NCH.  Exception:  problem in
     startup year may have resulted in this
     special IME payment request being erroneously
     stored in NCH.  If present, disregard claim
     as condition code '69' is not valid NCH
     claim.
70 = Self-administered EPO - Billing is
     for a home dialysis patient who self
     administers EPO.
71 = Full care in unit - Billing is for a
     patient who received staff assisted
     dialysis services in a hospital or
     renal dialysis facility.
72 = Self care in unit - Billing is for a
     patient who managed his own dialysis
     services without staff assistance in a
     hospital or renal dialysis facility.
73 = Self care training - Billing is for
     special dialysis services where the
```

```
1      CLM_RLT_COND_TB                              Claim Related Condition Table
       ---------------                              -----------------------------
```

```
                                        patient and helper (if necessary) were
                                        learning to perform dialysis.
```

74 = Home - Billing is for a patient who
     received dialysis services at home.
75 = Home 100% reimbursement -
     (not to be used for services after 4/15/90)
     The billing is for home dialsis patient using
     a dialysis machine that was purchased
     under the 100% program.
76 = Back-up facility - Billing is for a
     patient who received dialysis services
     in a back-up facility.
77 = Provider accepts or is obligated/
     required due to contractual agreement
     or law to accept payment by a primary
     payer as payment in full - Medicare
     pays nothing.
78 = New coverage not implemented by HMO -
     eff 3/92, indicates newly covered
     service under Medicare for which HMO
     does not pay.
79 = CORF services provided off site -
     Code indicates that physical therapy,
     occupational therapy, or speech path-
     ology services were provided off site.
80 - 99 = Reserved for state assignment.
A0 = CHAMPUS external partnership program
     special program indicator code. (eff 10/93)
A1 = EPSDT/CHAP - Early and periodic
     screening diagnosis and treatment
     special program indicator code. (eff 10/93)
A2 = Physically handicapped children's
     program - Services provided receive
     special funding through Title 8 of
     the Social Security Act or the CHAMPUS
     program for the handicapped. (eff 10/93)
A3 = Special federal funding - Designed for
     uniform use by state uniform billing
     committees.
     Special program indicator code (eff 10/93)
A4 = Family planning - Designed for
     uniform use by state uniform billing
     committees.
     Special program indicator code (eff 10/93)
A5 = Disability - Designed for uniform
     use by state uniform billing

```
                              committees.
                              Special program indicator code (eff 10/93)
                    A6 = PPV/Medicare - Identifies that
                         pneumococcal pneumonia 100% payment
                         vaccine (PPV) services should be
                         reimbursed under a special Medicare
                         program provision.
                         Special program indicator code (eff 10/93)
                    A7 = Induced abortion to avoid danger to
                         woman's life.
                         Special program indicator code (eff 10/93)
                    A8 = Induced abortion - Victim of rape/
```

```
1      CLM_RLT_COND_TB                          Claim Related Condition Table
       ---------------                          -----------------------------
```

```
                              incest.
                              Special program indicator code (eff 10/93)
                    A9 = Second opinion surgery - Services
                         requested to support second opinion
                         on surgery.  Part B deductible and
                         coinsurance do not apply.
                         Special program indicator code (eff 10/93)
                    B0 = Special program indicator
                         Reserved for national assignment.
                    B1 = Special program indicator
                         Reserved for national assignment.
                    B2 = Special program indicator
                         Reserved for national assignment.
                    B3 = Special program indicator
                         Reserved for national assignment.
                    B4 = Special program indicator
                         Reserved for national assignment.
                    B5 = Special program indicator
                         Reserved for national assignment.
                    B6 = Special program indicator
                         Reserved for national assignment.
                    B7 = Special program indicator
                         Reserved for national assignment.
                    B8 = Special program indicator
                         Reserved for national assignment.
                    B9 = Special program indicator
                         Reserved for national assignment.
                    C0 = Reserved for national assignment.
                    C1 = Approved as billed - The services
```

```
                              provided for this billing period have
                              been reviewed by the PRO/UR or
                              intermediary and are fully approved
                              including any day or cost outlier. (eff 10/93)
                         C2 = Automatic approval as billed based on
                              focused review.  (No longer used for
                              Medicare)
                              PRO approval indicator services (eff 10/93)
                         C3 = Partial approval - The services
                              provided for this billing period have
                              been reviewed by the PRO/UR or
                              intermediary and some portion has been
                              denied (days or services). (eff 10/93)
                         C4 = Admission/services denied - Indicates
                              that all of the services were denied
                              by the PRO/UR.
                              PRO approval indicator services (eff 10/93)
                         C5 = Postpayment review applicable - PRO/UR
                              review to take place after payment.
                              PRO approval indicator services (eff 10/93)
                         C6 = Admission preauthorization - The
                              PRO/UR authorized this admission/
                              service but has not reviewed the
                              services provided.
                              PRO approval indicator services (eff 10/93)
                         C7 = Extended authorization - the PRO has
                              authorized these services for an
                              extended length of time but has not
                              reviewed the services provided.
```

```
1       CLM_RLT_COND_TB                          Claim Related Condition Table
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                              PRO approval indicator services (eff 10/93)
                         C8 = Reserved for national assignment.
                              PRO approval indicator services (eff 10/93)
                         C9 = Reserved for national assignment.
                              PRO approval indicator services (eff 10/93)
                         D0 = Changes to service dates.
                              Change condition (eff 10/93)
                         D1 = Changes in charges.
                              Change condition (eff 10/93)
                         D2 = Changes in revenue codes/HCPCS.
                              Change condition (eff 10/93)
                         D3 = Second or subsequent interim
```

            PPS bill.
            Change condition (eff 10/93)
     D4 = Change in grouper input (diagnosis
            and/or procedures are changed resulting
            in a different DRG).
            Change condition (eff 10/93)
     D5 = Cancel only to correct a beneficiary
            claim account number or provider
            identification number.
            change condition (eff 10/93)
     D6 = Cancel only to repay a duplicate
            payment or OIG overpayment (includes
            cancellation of an OP bill containing
            services required to be included on the
            IP bill). Change condition eff 10/93.
     D7 = Change to make Medicare the secondary
            payer.
            Change condition (eff 10/93)
     D8 = Change to make Medicare the primary
            payer.
            Change condition (eff 10/93)
     D9 = Any other change.
            Change condition (eff 10/93)
     E0 = Change in patient status.
            Change condition (eff 10/93)
     EY = National Emphysema Treatment Trial (NETT)
            or Lung Volume Reduction Surgery (LVRS)
            clinical study (eff. 11/97)
     G0 = Multiple medical visits occur on the same
            day in the same revenue center but visits
            are distinct and constitute independent
            visits (allows for payment under outpatient
            PPS -- eff. 7/3/00).
     M0 = All inclusive rate for outpatient services.
            (payer only code)
     M1 = Roster billed influenza virus vaccine.
            (payer only code)
            Eff 10/96, also includes pneumoccocal
            pneumonia vaccine (PPV)
     M2 = HH override code - home health total
            reimbursement exceeds the $150,000 cap
            or the number of total visits exceeds the
            150 limitation. (eff 4/3/95)
            (payer only code)

                        W0 = United Mine Workers of America (UMWA)
                             SNF demonstration indicator (eff 1/97);
1   CLM_RLT_COND_TB   Claim Related Condition Table
        ----------------   -----------------------------

                             but no claims transmitted until 2/98)

1   CLM_RLT_OCRNC_TB   Claim Related Occurrence Table
        ----------------   -----------------------------

                        01 = Auto accident - The date of an auto
                             accident.
                        02 = No-fault insurance involved, including
                             auto accident/other - The date of an
                             accident where the state has applicable
                             no-fault liability laws, (i.e., legal
                             basis for settlement without admission
                             or proof of guilt).
                        03 = Accident/tort liability - The date of
                             an accident resulting from a third
                             party's action that may involve a civil
                             court process in an attempt to require
                             payment by the third party, other than
                             no-fault liability.
                        04 = Accident/employment related - The
                             date of an accident relating to the
                             patient's employment.
                        05 = Other accident - The date of an accident
                             not described by the codes 01 thru 04.
                        06 = Crime victim - Code indicating the
                             date on which a medical condition
                             resulted from alleged criminal action
                             committed by one or more parties.
                        07 = Reserved for national assignment.
                        08 = Reserved for national assignment.
                        11 = Onset of symptoms/illness - The date
                             the patient first became aware of
                             symptoms/illness.
                        12 = Date of onset for a chronically
                             dependent individual - Code indicates
                             the date the patient/bene became
                             a chronically dependent individual.
                        13 = Reserved for national assignment.

```
              14 = Reserved for national assignment.
              15 = Reserved for national assignment.
              16 = Reserved for national assignment.
              17 = Date outpatient occupational therapy
                   plan established or last reviewed -
                   Code indicating the date an occupational
                   therapy plan was established or
                   last reviewed (eff 3/93)
              18 = Date of retirement (patient/bene)
                   - Code indicates the date of retirement
                   for the patient/bene.
              19 = Date of retirement spouse -
                   Code indicates the date of retirement
                   for the patient's spouse.
              20 = Guarantee of payment began - The date
                   on which the provider began claiming
                   Medicare payment under the guarantee
                   of payment provision.
              21 = UR notice received - Code indicating
                   the date of receipt by the hospital
                   of the UR committee's finding that the
                   admission or future stay was not
                   medically necessary.
              22 = Active care ended - The date on which
```

```
1      CLM_RLT_OCRNC_TB                          Claim Related Occurrence Table
       ----------------                          ------------------------------
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                   a covered level of care ended in a SNF
                   or general hospital, or date active care
                   ended in a psychiatric or tuberculosis
                   hospital.  (For use by intermediary only)
              23 = Reserved for national assignment
                   (eff 10/93).
                   Benefits exhausted - The last date
                   for which benefits can be paid.
                   (term 9/30/93; replaced by code A3)
              24 = Date insurance denied - The date the
                   insurer's denial of coverage was
                   received by a higher priority payer.
              25 = Date benefits terminated by primary
                   payer - The date on which coverage
                   (including worker's compensation benefits
                   or no-fault coverage) is no longer
                   available to the patient.
```

```
                    26 = Date skilled nursing facility (SNF)
                         bed available - The date on which a SNF
                         bed became available to a hospital
                         inpatient who required only SNF level of
                         care.
                    27 = Date home health plan established or
                         last reviewed - Code indicating the
                         date a home health plan of treatment
                         was established or last reviewed.
                         not used by hospital unless owner of facility
                    28 = Date comprehensive outpatient rehabi-
                         litation plan established or last re-
                         viewed - Code indicating the date a
                         comprehensive outpatient rehabilitation
                         plan was established or last reviewed.
                         not used by hospital unless owner of facility
                    29 = Date OPT plan established or last
                         reviewed - the date a plan of treatment
                         was established for outpatient physical
                         therapy.
                         Not used by hospital unless owner of facility
                    30 = Date speech pathology plan treatment
                         established or last reviewed - The date
                         a speech pathology plan of treatment
                         was established or last reviewed.
                         Not used by hospital unless owner of facility
                    31 = Date bene notified of intent
                         to bill (accommodations) - The date of
                         the notice provided to the patient by
                         the hospital stating that he no longer
                         required a covered level of IP care.
                    32 = Date bene notified of intent
                         to bill (procedures or treatment) - The
                         date of the notice provided to the patient
                         by the hospital stating requested care
                         (diagnostic procedures or treatments) is
                         not considered reasonable or necessary.
                    33 = First day of the Medicare coordination
                         period for ESRD bene - During
                         which Medicare benefits are secondary
                         to benefits payable under an EGHP.
  1      CLM_RLT_OCRNC_TB                      Claim Related Occurrence Table
         ----------------                      ------------------------------
```

Required only for ESRD beneficiaries.
34 = Date of election of extended care
     facilities - The date the guest elected
     to receive extended care services (used
     by Christian Science Sanatoria only).
35 = Date treatment started for physical
     therapy - Code indicates the date
     services were initiated by the billing
     provider for physical therapy.
36 = Date of discharge for the IP
     hospital stay when patient
     received a transplant procedure
     - Hospital is billing for
     immunosuppressive drugs.
37 = The date of discharge
     for the IP hospital stay when
     patient received a noncovered
     transplant procedure - Hospital
     is billing for immunosuppresive drugs.
38 = Date treatment started for home IV
     therapy - Date the patient was first
     treated in his home for IV therapy.
39 = Date discharged on a continuous
     course of IV therapy - Date the patient
     was discharged from the hospital on a
     continuous course of IV therapy.
40 = Scheduled date of admission - The
     date on which a patient will be admitted
     as an inpatient to the hospital.
     (This code may only be used on an
     outpatient claim.)
41 = The date on which the first
     outpatient diagnostic test was
     performed as part of a pre-admission
     testing (PAT) program. This code may
     only be used if a date of admission
     was scheduled prior to the administration
     of the test(s).
42 = Date of discharge/termination of hospice
     care - for the final bill for hospice
     care. Eff 5/93, definition revised to
     apply only to date patient revoked
     hospice election.
43 = Reserved for national assignment.

```
                    44 = Date treatment started for occupational
                         therapy - Code indicates the date
                         services were initiated by the billing
                         provider for occupational therapy.
                    45 = Date treatment started for speech
                         therapy - Code indicates the date
                         services were initiated by the billing
                         provider for speech therapy.
                    46 = Date treatment started for cardiac
                         rehabilitation - Code indicates the
                         date services were initiated by the
                         billing provider for cardiac
                         rehabilitation.
                    47 = Noncovered Outlier Stay Began- code
```

1   CLM_RLT_OCRNC_TB   Claim Related Occurrence Table
         ----------------   ------------------------------

```
                         indicates the date that cost outlier
                         status began and no Medicare payment
                         will be made because all benefits have
                         been exhausted during the inlier stay or
                         the beneficiary does not elect to use life
                         time reserve days (to be implemented in
                         1999).
                    48 = Payer code - Code reserved for
                         internal use only by third party
                         payers.  HCFA assigns as needed for
                         your use.  Providers will not report it.
                    49 = Payer code - Code reserved for
                         internal use only by third party
                         payers.  HCFA assigns as needed for
                         your use.  Providers will not report it.
               50 - 69 = Reserved for state assignment
                    A1 = Birthdate, Insured A - The birthdate of
                         the individual in whose name the insurance
                         is carried. (Eff 10/93)
                    A2 = Effective date, Insured A policy - A
                         code indicating the first date insurance
                         is in force. (eff 10/93)
                    A3 = Benefits exhausted - Code indicating
                         the last date for which benefits are
                         available and after which no payment
                         can be made to payer A.  (eff 10/93)
                    B1 = Birthdate, Insured B - The birthdate of
```

                      the individual in whose name the insurance
                      is carried. (eff 10/93)
                B2 = Effective date, Insured B policy – A
                      code indicating the first date insurance
                      is in force. (eff 10/93)
                B3 = Benefits exhausted - code indicating
                      the last date for which benefits are
                      available and after which no payment
                      can be made to payer B. (eff 10/93)
                C1 = Birthdate, Insured C - The birthdate of
                      the individual in whose name the insurance
                      is carried. (eff 10/93)
                C2 = Effective date, Insured C policy – A
                      code indicating the first date insurance
                      is in force. (eff 10/93)
                C3 = Benefits exhausted - Code indicating
                      the last date for which benefits are
                      available and after which no payment
                      can be made to payer C. (eff 10/93)

1   CLM_SRC_IP_ADMSN_TB   Claim Source Of Inpatient Admission Table
       -------------------   ---

                      For Inpatient/SNF Claims:

                0 = ANOMALY: invalid value, if present,
                      translate to '9'
                1 = Physician referral - The patient was
                      admitted upon the recommendation of
                      a personal physician.
                2 = Clinic referral - The patient was
                      admitted upon the recommendation of
                      this facility's clinic physician.
                3 = HMO referral - The patient was admitted
                      upon the recommendation of an health
                      maintenance organization (HMO)
                      physician.
                4 = Transfer from hospital - The patient
                      was admitted as an inpatient transfer
                      from an acute care facility.
                5 = Transfer from a skilled nursing
                      facility (SNF) - The patient was

```
                     admitted as an inpatient transfer
                     from a SNF.
                 6 = Transfer from another health care
                     facility - The patient was admitted
                     as a transfer from a health care
                     facility other than an acute care
                     facility or SNF.
                 7 = Emergency room - The patient was
                     admitted upon the recommendation of
                     this facility's emergency room
                     physician.
                 8 = Court/law enforcement - The patient was
                     admitted upon the direction of a
                     court of law or upon the request of
                     a law enforcement agency's
                     representative.
                 9 = Information not available -  The means
                     by which the patient was admitted is
                     not known.
                 A = Transfer from a Critical Access Hospital -
                     patient was admitted/referred to this
                     facility as a transfer from a Critical
                     Access Hospital.
                 ----------------------------------------
                   **For Newborn Type of Admission**

                 1 = Normal delivery - A baby delivered with
                     out complications.
                 2 = Premature delivery - A baby delivered
                     with time and/or weight factors
                     qualifying it for premature status.
                 3 = Sick baby - A baby delivered with
                     medical complications, other than those
                     relating to premature status.
                 4 = Extramural birth - A baby delivered in
                     a nonsterile environment.
                 5-8 = Reserved for national assignment.
```

1	CLM_SRC_IP_ADMSN_TB	Claim Source Of Inpatient Admission Table
	-------------------	--

```
                 9 = Information not available.
```

1	CLM_SRVC_CLSFCTN_TYPE_TB	Claim Service Classification Type Table
	------------------------	--

For facility type code 1 thru 6, and 9

1 = Inpatient (including Part A)
2 = Hospital based or Inpatient (Part B only)
    or home health visits under Part B
3 = Outpatient (HHA-A also)
4 = Other (Part B)
5 = Intermediate care - level I
6 = Intermediate care - level II
7 = Subacute Inpatient
    (formerly Intermediate care - level III)
8 = Swing beds (used to indicate billing for
    SNF level of care in a hospital with an
    approved swing bed agreement)
9 = Reserved for national assignment

For facility type code 7

1 = Rural health
2 = Hospital based or independent renal
    dialysis facility
3 = Free-standing provider based federally
    qualified health center (eff 10/91)
4 = Other Rehabilitation Facility (ORF) and
    Community Mental Health Center (CMHC)
    (eff 10/91 - 3/97); ORF only (eff. 4/97)
5 = Comprehensive Rehabilitation Center
      (CORF)
6 = Community Mental Health Center (CMHC) (eff 4/97)
7-8 = Reserved for national assignment
9 = Other

For facility type code 8

1 = Hospice (non-hospital based)
2 = Hospice (hospital based)
3 = Ambulatory surgical center in hospital
    outpatient department
4 = Freestanding birthing center
5 = Critical Access Hospital (eff. 10/99)
    formerly Rural primary care hospital
    (eff. 10/94)

6-8 = Reserved for national use
9 = Other

1   CLM_TRANS_TB   Claim Transaction Table
           ------------   -----------------------

0 = Religious NonMedical Health Care Institutions (RNHCI)
    bill (prior to 8/00, Christian Science bill), SNF bill,
    or state buy-in
1 = Psychiatric hospital facility bill or dummy psychiatric
2 = Tuberculosis hospital facility bill
3 = General care hospital facility bill or dummy LRD
4 = Regular SNF bill
5 = Home health agency bill (HHA)
6 = Outpatient hospital bill
C = CORF bill - type of OP bill in the HHA bill format
    (obsoleted 7/98)
H = Hospice bill

1   CLM_VAL_TB   Claim Value Table
           ----------   -----------------

04 = Inpatient professional component
     charges which are combined billed -
     For use only by some all inclusive
     rate hospitals. (Eff 9/93)
05 = Professional component included in
     charges and also billed separately to
     carrier - For use on Medicare and
     Medicaid bills if the state requests
     this information.
06 = Medicare blood deductible - Total
     cash blood deductible (Part A blood
     deductible).
07 = Medicare cash deductible (term 9/30/93)
     reserved for national assignment.
     (eff 10/93)
08 = Medicare Part A lifetime reserve amount
     in first calendar year - Lifetime reserve
     amount charged in the year of admission.
     (not stored in NCH until 2/93)
09 = Medicare Part A coinsurance amount in

                    the first calendar year - Coinsurance
                    amount charged in the year of admission.
                    (not stored in NCH until 2/93)
              10 = Medicare Part A lifetime reserve amount
                    in the second calendar year - Lifetime
                    reserve amount charged in the year of
                    discharge where the bill spans two
                    calendar years.
                    (not stored in NCH until 2/93)
              11 = Medicare Part A coinsurance amount in
                    the second calendar year - Coinsurance
                    amount charged in the year of discharge
                    where the bill spans two calendar years
                    (not stored in NCH until 2/93)
              12 = Amount is that portion of
                    higher priority EGHP insurance payment
                    made on behalf of aged bene
                    provider applied to Medicare
                    covered services on this bill.
                    Six zeroes indicate provider
                    claimed conditional Medicare payment.
              13 = Amount is that portion of higher
                    priority EGHP insurance payment made on
                    behalf of ESRD bene provider
                    applied to Medicare covered services
                    on this bill. Six zeroes indicate
                    the provider claimed conditional
                    Medicare payment.
              14 = That portion of payment from higher
                    priority no fault auto/other
                    liability insurance made on behalf of bene
                    provider applied to Medicare covered
                    services on this bill. Six zeroes indicate
                    provider claimed conditional payment
              15 = That portion of a payment from a
                    higher priority WC plan made on behalf
                    of a bene that the provider applied to

1   CLM_VAL_TB   Claim Value Table
           ----------   -----------------

                    Medicare covered services on this bill. Six
                    zeroes indicate the provider claimed
                    conditional Medicare payment.
              16 = That portion of a payment from

        higher priority PHS or other federal
        agency made on behalf of a
        bene the provider applied
        to Medicare covered services on this
        bill. Six zeroes indicate
        provider claimed conditional Medicare
        payment.
17 = Operating Outlier amount - Providers do
        not report this. For payer internal use
        only. Indicates the amount of day or
        cost outlier payment to be made.
        (Do not include any PPS capital outlier
        payment in this entry).
18 = Operating Disproportionate share amount -
        Providers do not report this. For
        payer internal use only. Indicates the
        disproportionate share amount applicable
        to the bill. Use the amount provided by
        the disproportionate share field in PRICER.
        (Do not include any PPS capital DSH adjust-
        ment in this entry).
19 = Operating Indirect medical education amount -
        Providers do not report this. For
        payer internal use only. Indicates the
        indirect medical education amount applicable
        to the bill. (Do not include PPS capital
        IME adjustment in this entry).
20 = Total payment sent provider for capital
        under PPS, including HSP, FSP, outlier,
        old capital, DSH adjustment, IME
        adjustment, and any exception amount.
        (used 10/1/91 - 3/1/92 for provider
        reporting. Payer only code eff 9/93.)
21 = Catastrophic - Medicaid - Eligibility
        requirements to be determined at state
        level. (Medicaid specific/deleted 9/93)
22 = Surplus - Medicaid - Eligibility
        requirements to be determined at state
        level. (Medicaid specific/deleted 9/93)
23 = Recurring monthly income - Medicaid -
        Eligibility requirements to be
        determined at state level. (Medicaid
        specific/deleted 9/93)
24 = Medicaid rate code - Medicaid -

          Eligibility requirements to be
          determined at state level. (Medicaid
          specific/deleted 9/93)
31 = Patient liability amount - Amount
          shown is that which you or the PRO
          approved to charge the bene for
          noncovered accommodations, diagnostic
          procedures or treatments.
37 = Pints of blood furnished - Total
          number of pints of whole blood or units

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1          CLM_VAL_TB                                      Claim Value Table
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          of packed red cells furnished to the
          patient. (eff 10/93)
38 = Blood deductible pints - The number
          of unreplaced pints of whole blood or
          units of packed red cells furnished for
          which the patient is responsible.
          (eff 10/93)
39 = Pints of blood replaced - The total
          number of pints of whole blood or units
          of packed red cells furnished to the
          patient that have been replaced by or
          on behalf of the patient. (eff 10/93)
40 = New coverage not implemented by HMO -
          amount shown is for inpatient charges
          covered by HMO (eff 3/92).
          (use this code when the bill includes
          inpatient charges for newly covered
          services which are not paid by HMO.)
41 = Amount is that portion of
          a payment from higher priority BL
          program made on behalf of
          bene the provider applied
          to Medicare covered services on this
          bill. Six zeroes indicate the
          provider claimed conditional Medicare
          payment.
42 = Amount is that portion of a payment
          from higher priority VA made on behalf
          of bene the provider applied
          to Medicare covered services on this
          bill. Six zeroes indicate the

                    provider claimed conditional Medicare
                    payment.
               43 = Disabled bene under age 65 with
                    LGHP - Amount is that portion of
                    a payment from a higher priority LGHP
                    made on behalf of a disabled Medicare
                    bene the provider applied to
                    Medicare covered services on this bill.
               44 = Amount provider agreed to accept from
                    primary payer when amount less than charges
                    but more than payment received -
                    When a lesser amount is received and the
                    received amount is less than charges, a
                    Medicare secondary payment is due.
               46 = Number of grace days - Following the
                    date of the PRO/UR determination, this
                    is the number of days determined by the
                    PRO/UR to be necessary to arrange for
                    the patient's post-discharge care.
                    (eff 10/93)
               47 = Any liability insurance - Amount
                    is that portion from a higher priority
                    liability insurance made on behalf of
                    Medicare bene the provider
                    is applying to Medicare covered
                    services on this bill. (Eff 9/93)
               48 = Hemoglobin reading - The latest

1   CLM_VAL_TB   Claim Value Table
           ----------   -----------------

                    hemoglobin reading taken during this
                    billing cycle.
               49 = Latest hematocrit reading taken
                    during billing cycle - Usually
                    reported in two pos. (a percentage) to
                    left of the dollar/cent delimiter.
                    if provided with a
                    a decimal, use the 3rd pos. to right
                    of the delimiter for the third digit.
               50 = Physical therapy visits - Indicates
                    the number of physical therapy
                    visits from onset (at billing provider)
                    through this billing period.
               51 = Occupational therapy visits - Indicates

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            the number of occupational therapy
            visits from onset (at the billing
            provider) through this billing period.
52 = Speech therapy visits - Indicates
            the number of speech therapy
            visits from onset (at billing provider)
            through this billing period.
53 = Cardiac rehabilitation - Indicates
            the number of cardiac rehabilitation
            visits from onset (at billing
            provider) through this billing period.
54 = Reserved for national assignment.
55 = Reserved for national assignment.
56 = Hours skilled nursing provided - The
            number of hours skilled nursing
            provided during the billing period.  Count
            only hours spent in the home.
57 = Home health visit hours - The number
            of home health aide services provided
            during the billing period.  Count only
            the hours spent in the home.
58 = Arterial blood gas - Arterial blood
            gas value at beginning of each reporting
            period for oxygen therapy. This
            value or value 59 will be required on
            the initial bill for oxygen therapy and
            on the fourth month's bill.
59 = Oxygen saturation - Oxygen saturation
            at the beginning of each reporting
            period for oxygen therapy.  This value or
            value 58 will be required on the
            initial bill for oxygen therapy and on
            the fourth month's bill.
60 = HHA branch MSA - MSA in which HHA
            branch is located.
61 = Location of HHA service or hospice
            service - the balanced budget act
            (BBA) requires that the geographic
            location of where the service was
            provided be furnished instead of the
            geographic location of the provider.
            (eff. 10/1/97)
62 = Number of Part A home health visits
            accrued during a period of continuous
```

1   CLM_VAL_TB   Claim Value Table
          ----------   ----------------

                        care - necessitated by the change in
                        payment basis under HH PPS (eff. 10/00)
     63 = Number of Part B home health visits
           accrued during a period of continuous
           care - necessitated by the change in
           payment basis under HH PPS (eff. 10/00)
     64 = Amount of home health payments attributed
           to the Part A trust fund in a period
           of continuous care - necessitated by the
           change in payment basis under HH PPS
           (eff. 10/00)
     65 = Amount of home health payments attributed
           to the Part B trust fund in a period
           of continuous care - necessitated by the
           change in payment basis under HH PPS
           (eff. 10/00)
     66 = Reserved for national assignment.
     67 = Peritoneal dialysis - The number of
           hours of peritoneal dialysis provided
           during the billing period (only the
           hours spent in the home).
           (eff. 10/97)
     68 = EPO drug - Number of units of EPO
           administered relating to the billing
           period.
     69 = Reserved for national assignment
     70 = Interest amount - (Providers do not
           report this.) Report the amount
           applied to this bill.
     71 = Funding of ESRD networks - (Providers
           do not report this.) Report the
           amount the Medicare payment was
           reduced to help fund the ESRD networks.
     72 = Flat rate surgery charge - Code
           indicates the amount of the charge for
           outpatient surgery where the hospital
           has such a charging structure.
     73 = Drug deductible - (For internal use by
           third party payers only). Report the
           amount of the drug deductible to be
           applied to the claim.

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           74 = Drug coinsurance - (For internal use
                by third party payers only).  Report
                the amount of drug coinsurance to be
                applied to the claim.
           75 = Gramm/Rudman/Hollings - (Providers do
                not report this.)  Report the amount of
                the sequestration applied to this bill.
           76 = Report provider's percentage of
                billed charges interim rate during
                billing period.  Applies to OP
                hospital, SNF and HHA claims
                where interim rate is applicable.
                Report to left of dollar/cents delimiter.
                (TP payers internal use only)
           77 = Payer code - This codes is set
                aside for payer use only.  Providers
                do not report these codes.
```

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1          CLM_VAL_TB                                   Claim Value Table
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           78 = Payer code - This codes is set
                aside for payer use only.  Providers
                do not report these codes.
           79 = Payer code - This code is set
                aside for payer use only.  Providers
                do not report these codes.
           80 - 99 = Reserved for state assignment.
           A1 = Deductible Payer A - The amount
                assumed by the provider to be applied
                to the patient's deductible amount
                involving the indicated payer. (eff 10/93)
                - Prior value 07
           A2 = Coinsurance Payer A - The amount assumed
                by the provider to be applied to the
                patient's Part B coinsurance amount
                involving the indicated payer. (eff 10/93)
           A4 = Self-administered drugs administered in an
                emergency situation - Ordinarily the only
                noncovered self-administered drug
                paid for under Medicare in an emergency
                situation is insulin administered to a
                patient in a diabetic coma. (eff 7/97)
           B1 = Deductible Payer B - The amount
                assumed by the provider to be applied
```

                    to the patient's deductible amount
                    involving the indicated payer. (eff 10/93)
                    - Prior value 07
          B2 = Coinsurance Payer B - the amount assumed
                    by the provider to be applied to the
                    patient's Part B coinsurance amount
                    involving the indicated payer. (eff 10/93)
          C1 = Deductible Payer C - The amount
                    assumed by the provider to be applied
                    to the patient's deductible amount
                    involving the indicated payer. (eff 10/93)
                    - Prior value 07
          C2 = Coinsurance Payer C - The amount assumed
                    by the provider to be applied to the
                    patient's Part B coinsurance amount
                    involving the indicated payer. (eff 10/93)
          Y1 = Part A demo payment - Portion of the
                    payment designated as reimbursement for
                    Part A services per the ORD contract. No
                    deductible or coinsurance has been
                    applied. (eff. 5/97)
          Y2 = Part B demo payment - Portion of the
                    payment designated as reimbursement for
                    Part B services for the ORD contract.
                    No deductible or coinsurance has been
                    applied. (eff. 5/97)
          Y3 = Part B coinsurance - Amount of Part B
                    coinsurance applied by the intermediary
                    to this demo claim.   (eff. 5/97)
          Y4 = Conventional provider Part A payment -
                    Amount Medicare would have reimbursed
                    the provider for Part A services if
                    there had been no demo. (eff. 5/97)

1 CTGRY_EQTBL_BENE_IDENT_TB   Category Equatable Beneficiary Identification Code (BIC) Table
   -------------------------   ---

          NCH BIC   SSA Categories
          -------   --------------

          A = A;J1;J2;J3;J4;M;M1;T;TA
          B = B;B2;B6;D;D4;D6;E;E1;K1;K2;K3;K4;W;W6;
               TB(F);TD(F);TE(F);TW(F)

```
B1 = B1;BR;BY;D1;D5;DC;E4;E5;W1;WR;TB(M)
     TD(M);TE(M);TW(M)
B3 = B3;B5;B9;D2;D7;D9;E2;E3;K5;K6;K7;K8;W2
     W7;TG(F);TL(F);TR(F);TX(F)
B4 = B4;BT;BW;D3;DM;DP;E6;E9;W3;WT;TG(M)
     TL(M);TR(M);TX(M)
B8 = B8;B7;BN;D8;DA;DV;E7;EB;K9;KA;KB;KC;W4
     W8;TH(F);TM(F);TS(F);TY(F)
BA = BA;BK;BP;DD;DL;DW;E8;EC;KD;KE;KF;KG;W9
     WC;TJ(F);TN(F);TT(F);TZ(F)
BD = BD;BL;BQ;DG;DN;DY;EA;ED;KH;KJ;KL;KM;WF
     WJ;TK(F);TP(F);TU(F);TV(F)
BG = BG;DH;DQ;DS;EF;EJ;W5;TH(M);TM(M);TS(M)
     TY(M)
BH = BH;DJ;DR;DX;EG;EK;WB;TJ(M);TN(M);TT(M)
     TZ(M)
BJ = BJ;DK;DT;DZ;EH;EM;WG;TK(M);TP(M);TU(M)
     TV(M)
C1 = C1;TC
C2 = C2;T2
C3 = C3;T3
C4 = C4;T4
C5 = C5;T5
C6 = C6;T6
C7 = C7;T7
C8 = C8;T8
C9 = C9;T9
F1 = F1;TF
F2 = F2;TQ
F3-F8 = Equatable only to itself (e.g., F3 IS
         equatable to F3)
CA-CZ = Equatable only to itself.  (e.g., CA is
         only equatable to CA)
```

RRB Categories

```
10 = 10
11 = 11
13 = 13;17
14 = 14;16
15 = 15
43 = 43
45 = 45
```

```
                              46 = 46
                              80 = 80
                              83 = 83
                              84 = 84;86
                              85 = 85
```

1 DMERC_LINE_SCRN_RSLT_IND_TB   DMERC Line Screen Result Indicator Table
  ----------------------------   ---

                         A = Denied for lack of medical necessity;
                             highest level of review was automated
                             level I review
                         B = Reduced (partially denied) for lack
                             of medical necessity; highest level
                             of review was automated level I review
                         C = Denied as statutorily noncovered;
                             highest level of review was automated
                             level I review
                         D = Reserved for future use
                         E = Paid after automated level I review
                         F = Denied for lack of medical necessity;
                             highest level of review was manual
                             level I review
                         G = Reduced (partially denied) for lack
                             of medical necessity; highest level
                             of review was manual level I review
                         H = Denied as statutorily noncovered;
                             highest level of review was manual
                             level I review
                         I = Denied for coding/unbundling reasons;
                             highest level of review was manual
                             level I review
                         J = Paid after manual level I review
                         K = Denied for lack of medical necessity;
                             highest level of review was manual
                             level II review
                         L = Reduced (partially denied) for lack
                             of medical necessity; highest level
                             of review was manual level II review
                         M = Denied as statutorily noncovered;
                             highest level of review was manual
                             level II review
                         N = Denied for coding/unbundling reasons;
```

```
                    highest level of review was manual
                    level II review
        O = Paid after manual level II review
        P = Denied for lack of medical necessity;
                    highest level of review was manual
                    level III review
        Q = Reduced (partially denied) for lack
                    of medical necessity; highest level
                    of review was manual level III review
        R = Denied as statutorily noncovered;
                    highest level of review was manual
                    level III review
        S = Denied for coding/unbundling reasons;
                    highest level of review was manual
                    level III review
        T = Paid after manual level III review
```

```
1   DMERC_LINE_SUPLR_TYPE_TB                           DMERC Line Supplier Type Table
    ------------------------                           -----------------------------
```

```
        0 = Clinics, groups, associations,
                    partnerships, or other entities
                    for whom the carrier's own ID number
                    has been assigned.
        1 = Physicians or suppliers billing as
                    solo practitioners for whom SSN's are
                    shown in the physician ID code field.
        2 = Physicians or suppliers billing as
                    solo practitioners for whom the carrier's
                    own physician ID code is shown.
        3 = Suppliers (other than sole proprietorship)
                    for whom EI numbers are used in coding the
                    ID field.
        4 = Suppliers (other than sole proprietorship)
                    for whom the carrier's own code has been
                    shown.
        5 = Institutional providers and
                    independent laboratories for whom EI
                    numbers are used in coding the ID field.
        6 = Institutional providers and
                    independent laboratories for whom the
                    carrier's own ID number is shown.
        7 = Clinics, groups, associations, or
```

        partnerships for whom EI numbers
        are used in coding the ID field.
    8 = Other entities for whom EI numbers
        are used in coding the ID field or
        proprietorship for whom EI numbers are
        used in coding the ID field.

1   DRG_OUTLIER_STAY_TB   Diagnosis Related Group Outlier Patient Stay Table
      -------------------   --

        0 = No outlier
        1 = Day outlier (condition code 60)
        2 = Cost outlier, (condition code 61)

            *** Non-PPS Only ***

        6 = Valid diagnosis related groups (DRG)
            received from the intermediary
        7 = HCFA developed DRG
        8 = HCFA developed DRG using patient status
            code
        9 = Not groupable

1   FI_CLM_ACTN_TB   Fiscal Intermediary Claim Action Table
      --------------   --------------------------------------

        1 = Original debit action (includes non-
            adjustment RTI correction items) - it
            will always be a 1 in regular bills.
        2 = Cancel by credit adjustment - used
            only in credit/debit pairs (under HHPPS,
            updates the RAP).
        3 = Secondary debit adjustment - used only
            in credit/debit pairs (under HHPPS, would
            be the final claim or an adjustment on
            a LUPA).
        4 = Cancel only adjustment (under HHPPS,
            RAP/final claim/LUPA).
        5 = Force action code 3
        6 = Force action code 2
        8 = Benefits refused (for inpatient bills,
            an 'R' nonpayment code must also be

```
                        present
       9 = Payment requested (used on bills that
           replace previously-submitted benefits-
           refused bills, action code 8.  In such
           cases a debit/credit pair is not re-
           quired.  For inpatient bills, a 'P'
           should be entered in the nonpayment
           code.)
```

```
1          FI_NUM_TB                           Fiscal Intermediary Number Table
           ---------                           -------------------------------


                        00010 = Alabama BC
                        00020 = Arkansas BC
                        00030 = Arizona BC
                        00040 = California BC (term. 12/00)
                        00050 = New Mexico BC/CO
                        00060 = Connecticut BC
                        00070 = Delaware BC - terminated 2/98
                        00080 = Florida BC
                        00090 = Florida BC
                        00101 = Georgia BC
                        00121 = Illinois - HCSC
                        00123 = Michigan - HCSC
                        00130 = Indiana BC/Administar Federal
                        00131 = Illinois - Administar
                        00140 = Iowa - Wellmark (term. 6/2000)
                        00150 = Kansas BC
                        00160 = Kentucky/Administar
                        00180 = Maine BC
                        00181 = Maine BC - Massachusetts
                        00190 = Maryland BC
                        00200 = Massachusetts BC - terminated 7/97
                        00210 = Michigan BC - terminated 9/94
                        00220 = Minnesota BC
                        00230 = Mississippi BC
                        00231 = Mississippi BC/LA
                        00232 = Mississippi BC
                        00241 = Missouri BC - terminated 9/92
                        00250 = Montana BC
                        00260 = Nebraska BC
                        00270 = New Hampshire/VT BC
                        00280 = New Jersey BC (term. 8/2000)
```

```
                            00290 = New Mexico BC - terminated 11/95
                            00308 = Empire BC
                            00310 = North Carolina BC
                            00320 = North Dakota BC
                            00332 = Community Mutual Ins Co; Ohio-Administar
                            00340 = Oklahoma BC
                            00350 = Oregon BC
                            00351 = Oregon BC/ID.
                            00355 = Oregon-CWF
                            00362 = Independence BC - terminated 8/97
                            00363 = Veritus, Inc (PITTS)
                            00370 = Rhode Island BC
                            00380 = South Carolina BC
                            00390 = Tennessee BC
                            00400 = Texas BC
                            00410 = Utah BC
                            00423 = Virginia BC; Trigon
                            00430 = Washington/Alaska BC
                            00450 = Wisconsin BC
                            00452 = Michigan - Wisconsin BC
                            00454 = United Government Services -
                                    Wisconsin BC (eff. 12/00)
                            00460 = Wyoming BC
                            00468 = N Carolina BC/CPRTIVA
                            00993 = BC/BS Assoc.
                            17120 = Hawaii Medical Service
```

```
1        FI_NUM_TB                         Fiscal Intermediary Number Table
         ---------                         --------------------------------
```

```
                            50333 = Travelers; Connecticut United Healthcare
                                    (terminated - date unknown)
                            51051 = Aetna California - terminated 6/97
                            51070 = Aetna Connecticut - terminated 6/97
                            51100 = Aetna Florida - terminated 6/97
                            51140 = Aetna Illinois - terminated 6/97
                            51390 = Aetna Pennsylvania - terminated 6/97
                            52280 = Mutual of Omaha
                            57400 = Cooperative, San Juan, PR
                            61000 = Aetna
```

```
1    FI_RQST_CLM_CNCL_RSN_TB                    Claim Cancel Reason Code Table
     -----------------------                    ------------------------------
```

```
         C = Coverage Transfer
         D = Duplicate Billing
         H = Other or blank
         L = Combining two beneficiary master records
         P = Plan Transfer
         S = Scramble
         ************For Action Code 4 ******************
         *********Effective with HHPPS - 10/00************
         A = RAP/Final claim/LUPA is cancelled by Interme-
             diary.  Does not delete episode.  Do not set
             cancellation indicator.
         B = RAP/Final claim/LUPA is cancelled by Interme-
             diary.  Does not delete episode.  Set
             cancellation indicator to 1.
         E = RAP/Final claim/LUPA is cancelled by Interme-
             diary.  Remove episode.
         F = RAP/Final claim/LUPA is cancelled by Provider.
             Remove episode.
```

```
1     GEO_SSA_STATE_TB                          State Table
      ----------------                          -----------


                     01 = Alabama
                     02 = Alaska
                     03 = Arizona
                     04 = Arkansas
                     05 = California
                     06 = Colorado
                     07 = Connecticut
                     08 = Delaware
                     09 = District of Columbia
                     10 = Florida
                     11 = Georgia
                     12 = Hawaii
                     13 = Idaho
                     14 = Illinois
                     15 = Indiana
                     16 = Iowa
                     17 = Kansas
                     18 = Kentucky
                     19 = Louisiana
                     20 = Maine
                     21 = Maryland
```

```
                        22 = Massachusetts
                        23 = Michigan
                        24 = Minnesota
                        25 = Mississippi
                        26 = Missouri
                        27 = Montana
                        28 = Nebraska
                        29 = Nevada
                        30 = New Hampshire
                        31 = New Jersey
                        32 = New Mexico
                        33 = New York
                        34 = North Carolina
                        35 = North Dakota
                        36 = Ohio
                        37 = Oklahoma
                        38 = Oregon
                        39 = Pennsylvania
                        40 = Puerto Rico
                        41 = Rhode Island
                        42 = South Carolina
                        43 = South Dakota
                        44 = Tennessee
                        45 = Texas
                        46 = Utah
                        47 = Vermont
                        48 = Virgin Islands
                        49 = Virginia
                        50 = Washington
                        51 = West Virginia
                        52 = Wisconsin
                        53 = Wyoming
                        54 = Africa
                        55 = Asia
                        56 = Canada & Islands
                        57 = Central America and West Indies
1       GEO_SSA_STATE_TB                                State Table
        ----------------                                -----------

                        58 = Europe
                        59 = Mexico
                        60 = Oceania
                        61 = Philippines
                        62 = South America
```

```
                63 = U.S. Possessions
                64 = American Samoa
                65 = Guam
                66 = Saipan
                97 = Northern Marianas
                98 = Guam
                99 = With 000 county code is American Samoa;
                     otherwise unknown
```

1   HCFA_PRVDR_SPCLTY_TB   HCFA Provider Specialty Table
        -------------------   ----------------------------

                            Prior to 5/92

```
                01 = General practice
                02 = General surgery
                03 = Allergy (revised 10/91 to mean allergy/
                     immunology)
                04 = Otology, laryngology, rhinology
                     revised 10/91 to mean otolaryngology)
                05 = Anesthesiology
                06 = Cardiovascular disease (revised 10/91
                     to mean cardiology)
                07 = Dermatology
                08 = Family practice
                09 = Gynecology--osteopaths only (deleted
                     10/91; changed to '16')
                10 = Gastroenterology
                11 = Internal medicine
                12 = Manipulative therapy (osteopaths only)
                     (revised 10/91 to mean osteopathic
                     manipulative therapy)
                13 = Neurology
                14 = Neurological surgery (revised 10/91 to
                     mean neurosurgery)
                15 = Obstetrics--osteopaths only (deleted
                     10/91; changed to '16')
                16 = OB-gynecology
                17 = Ophthalmology, otology, laryngology
                     rhinology--osteopaths only (deleted
                     10/91; changed to '18' if physicians
                     practice is more than 50% ophthalmology
                     or to '04' if physician's practice is
```

```
                          more than 50% otolaryngology.  If
                          practice is 50/50, choose specialty
                          with greater allowed charges.
                 18 = Ophthalmology
                 19 = Oral surgery (dentists only)
                 20 = Orthopedic surgery
                 21 = Pathologic anatomy, clinical pathology-
                      osteopaths only (deleted 10/91;
                      changed to '22')
                 22 = Pathology
                 23 = Peripheral vascular disease or surgery
                      (deleted 10/91; changed to '76')
                 24 = Plastic surgery (revised to mean
                      plastic and reconstructive surgery).
                 25 = Physical medicine and rehabilitation
                 26 = Psychiatry
                 27 = Psychiatry, neurology (osteopaths only)
                      (deleted 10/91; changed to '86')
                 28 = Proctology (revised 10/91 to mean
                      colorectal surgery).
                 29 = Pulmonary disease
                 30 = Radiology (revised 10/91 to mean
                      diagnostic radiology)
                 31 = Roentgenology, radiology (osteopaths)
                      (deleted 10/91; changed to '30')
                 32 = Radiation therapy--osteopaths (deleted
```

```
1     HCFA_PRVDR_SPCLTY_TB                      HCFA Provider Specialty Table
      --------------------                      ----------------------------
```

```
                      10/91; changed to '92')
                 33 = Thoracic surgery
                 34 = Urology
                 35 = Chiropractor, licensed (revised 10/91
                      to mean chiropractic)
                 36 = Nuclear medicine
                 37 = Pediatrics (revised 10/91 to mean
                      pediatric medicine)
                 38 = Geriatrics (revised 10/91 to mean
                      geriatric medicine)
                 39 = Nephrology
                 40 = Hand surgery
                 41 = Optometrist - services related to
                      condition of aphakia (revised 10/91 to
                      mean optometrist)
```

```
42 = Certified nurse midwife (added 7/88)
43 = Certified registered nurse anesthetist
     (revised 10/91 to mean CRNA,
     anesthesia assistant)
44 = Infectious disease
46 = Endocrinology (added 10/91)
48 = Podiatry - surgery chiropody (revised
     10/91 to mean podiatry)
49 = Miscellaneous (include ASCS)
51 = Medical supply company with C.O.
     certification (certified orthotist -
     certified by American Board for
     Certification in Prosthetics and
     Orthotics.
52 = Medical supply company with C.P.
     certification (certified prosthetist -
     certified by American Board for
     Certification in Prosthetics and Orthotics).
53 = Medical supply company with C.P.O.
     certification (certified prosthetist -
     orthotist - certified by American
     Board for Certification in Prosthetics
     and Orthotics).
54 = Medical supply company not included in
     51, 52, or 53.
55 = Individual certified orthotist
56 = Individual certified prosthetist
57 = Individual certified prosthetist -
     orthotist
58 = Individuals not included in 55,56 or 57
59 = Ambulance service supplier (e.g.
     private ambulance companies, funeral
     homes, etc.)
60 = Public health or welfare agencies
     (federal, state, and local)
61 = Voluntary health or charitable agencies
     (e.g. National Cancer Society, National
     Heart Association, Catholic Charities)
62 = Psychologist--billing independently
63 = Portable X-ray supplier--billing
     independently (revised 10/91 to mean
     portable X-ray supplier)
64 = Audiologist (billing independently)
```

1   HCFA_PRVDR_SPCLTY_TB   HCFA Provider Specialty Table

```
-------------------                    ---------------------------
                    65 = Physical therapist (independent practice)
                    66 = Rheumatology (added 10/91)
                    67 = Occupational therapist--independent
                         practice
                    68 = Clinical psychologist
                    69 = Independent laboratory--billing
                         independently (revised 10/91 to mean
                         independent clinical laboratory --
                         billing independently)
                    70 = Clinic or other group practice, except
                         Group Practice Prepayment Plan (GPPP)
                    71 = Group Practice Prepayment Plan - diagnostic
                         X-ray (do not use after 1/92)
                    72 = Group Practice Prepayment Plan - diagnostic
                         laboratory (do not use after 1/92)
                    73 = Group Practice Prepayment Plan -
                         physiotherapy (do not use after 1/92)
                    74 = Group Practice Prepayment Plan - occupational
                         therapy (do not use after 1/92)
                    75 = Group Practice Prepayment Plan - other
                         medical care (do not use after 1/92)
                    76 = Peripheral vascular disease
                         (added 10/91)
                    77 = Vascular surgery (added 10/91)
                    78 = Cardiac surgery (added 10/91)
                    79 = Addiction medicine (added 10/91)
                    80 = Clinical social worker (1991)
                    81 = Critical care-intensivists (added 10/91)
                    82 = Ophthalmology, cataracts specialty
                         (added 10/91; used only until 5/92)
                    83 = Hematology/oncology (added 10/91)
                    84 = Preventive medicine (added 10/91)
                    85 = Maxillofacial surgery (added 10/91)
                    86 = Neuropsychiatry (added 10/91)
                    87 = All other (e.g. drug and department
                         stores) (revised 10/91 to mean all
                         other suppliers)
                    88 = Unknown (revised 10/91 to mean
                         physician assistant)
                    90 = Medical oncology (added 10/91)
                    91 = Surgical oncology (added 10/91)
                    92 = Radiation oncology (added 10/91)
```

```
                                    93 = Emergency medicine (added 10/91)
                                    94 = Interventional radiology (added 10/91)
                                    95 = Independent physiological laboratory
                                         (added 10/91)
                                    96 = Unknown physician specialty
                                         (added 10/91)
                                    99 = Unknown--incl. social worker's
                                         psychiatric services (revised 10/91 to
                                         mean unknown supplier/provider)
                                         ---------------------------------------
                                                 **Effective 5/92**

                                    00 = Carrier wide
                                    01 = General practice
                                    02 = General surgery
                                    03 = Allergy/immunology
1       HCFA_PRVDR_SPCLTY_TB                      HCFA Provider Specialty Table
        --------------------                      -----------------------------

                                    04 = Otolaryngology
                                    05 = Anesthesiology
                                    06 = Cardiology
                                    07 = Dermatology
                                    08 = Family practice
                                    09 = Gynecology (osteopaths only)
                                         (discontinued 5/92 use code 16)
                                    10 = Gastroenterology
                                    11 = Internal medicine
                                    12 = Osteopathic manipulative therapy
                                    13 = Neurology
                                    14 = Neurosurgery
                                    15 = Obstetrics (osteopaths only)
                                         (discontinued 5/92 use code 16)
                                    16 = Obstetrics/gynecology
                                    17 = Ophthalmology, otology, laryngology,
                                         rhinology (osteopaths only)
                                         (discontinued 5/92 use codes 18 or 04
                                         depending on percentage of practice)
                                    18 = Ophthalmology
                                    19 = Oral surgery (dentists only)
                                    20 = Orthopedic surgery
                                    21 = Pathologic anatomy, clinical
                                         pathology (osteopaths only)
                                         (discontinued 5/92 use code 22)
```

```
                22 = Pathology
                23 = Peripheral vascular disease, medical
                     or surgical (osteopaths only)
                     (discontinued 5/92 use code 76)
                24 = Plastic and reconstructive surgery
                25 = Physical medicine and rehabilitation
                26 = Psychiatry
                27 = Psychiatry, neurology (osteopaths
                     only) (discontinued 5/92 use code 86)
                28 = Colorectal surgery (formerly
                     proctology)
                29 = Pulmonary disease
                30 = Diagnostic radiology
                31 = Roentgenology, radiology (osteopaths
                     only) (discontinued 5/92 use code 30)
                32 = Radiation therapy (osteopaths only)
                     (discontinued 5/92 use code 92)
                33 = Thoracic surgery
                34 = Urology
                35 = Chiropractic
                36 = Nuclear medicine
                37 = Pediatric medicine
                38 = Geriatric medicine
                39 = Nephrology
                40 = Hand surgery
                41 = Optometry (revised 10/93 to
                     mean optometrist)
                42 = Certified nurse midwife (eff 1/87)
                43 = Crna, anesthesia assistant
                     (eff 1/87)
                44 = Infectious disease
                45 = Mammography screening center
                46 = Endocrinology (eff 5/92)
```

```
1      HCFA_PRVDR_SPCLTY_TB                      HCFA Provider Specialty Table
       --------------------                      ----------------------------

                47 = Independent Diagnostic Testing Facility
                     (IDTF) (eff. 6/98)
                48 = Podiatry
                49 = Ambulatory surgical center
                     (formerly miscellaneous)
                50 = Nurse practitioner
                51 = Medical supply company with
                     certified orthotist (certified by
```

      American Board for Certification in
      Prosthetics And Orthotics)
52 = Medical supply company with
      certified prosthetist
      (certified by American Board for
      Certification In Prosthetics And
      Orthotics)
53 = Medical supply company with
      certified prosthetist-orthotist
      (certified by American Board for
      Certification in Prosthetics
      and Orthotics)
54 = Medical supply company not included
      in 51, 52, or 53. (Revised 10/93
      to mean medical supply company for DMERC)
55 = Individual certified orthotist
56 = Individual certified prosthetist
57 = Individual certified prosthetist-
      orthotist
58 = Individuals not included in 55, 56,
      or 57 (revised 10/93 to mean medical
      supply company with registered
      pharmacist)
59 = Ambulance service supplier, e.G.,
      private ambulance companies, funeral
      homes, etc.
60 = Public health or welfare agencies
      (federal, state, and local)
61 = Voluntary health or charitable
      agencies (e.G., National Cancer
      Society, National Heart Associiation,
      Catholic Charities)
62 = Psychologist (billing independently)
63 = Portable X-ray supplier
64 = Audiologist (billing independently)
65 = Physical therapist (independently
      practicing)
66 = Rheumatology (eff 5/92)
      Note: during 93/94 DMERC also used this
      to mean medical supply company with
      respiratory therapist
67 = Occupational therapist (independently
      practicing)
68 = Clinical psychologist

```
                       69 = Clinical laboratory (billing
                            independently)
                       70 = Multispecialty clinic or group
                            practice
                       71 = Diagnostic X-ray (GPPP) (not to
                            be assigned after 5/92)
1      HCFA_PRVDR_SPCLTY_TB                     HCFA Provider Specialty Table
       --------------------                     ----------------------------

                       72 = Diagnostic laboratory (GPPP)
                            (not to be assigned after 5/92)
                       73 = Physiotherapy (GPPP) (not to be
                            assigned after 5/92)
                       74 = Occupational therapy (GPPP)
                            (not to be assigned after 5/92)
                       75 = Other medical care (GPPP) (not to
                            assigned after 5/92)
                       76 = Peripheral vascular disease
                            (eff 5/92)
                       77 = Vascular surgery (eff 5/92)
                       78 = Cardiac surgery (eff 5/92)
                       79 = Addiction medicine (eff 5/92)
                       80 = Licensed clinical social worker
                       81 = Critical care (intensivists)
                            (eff 5/92)
                       82 = Hematology (eff 5/92)
                       83 = Hematology/oncology (eff 5/92)
                       84 = Preventive medicine (eff 5/92)
                       85 = Maxillofacial surgery (eff 5/92)
                       86 = Neuropsychiatry (eff 5/92)
                       87 = All other suppliers (e.g. drug and
                            department stores) (note: DMERC used
                            87 to mean department store from 10/93
                            through 9/94; recoded eff 10/94 to A7;
                            NCH cross-walked DMERC reported 87 to A7.
                       88 = Unknown supplier/provider specialty
                            (note: DMERC used 87 to mean grocery
                            store from 10/93 - 9/94; recoded eff
                            10/94 to A8; NCH cross-walked DMERC
                            reported 88 to A8.
                       89 = Certified clinical nurse specialist
                       90 = Medical oncology (eff 5/92)
                       91 = Surgical oncology (eff 5/92)
                       92 = Radiation oncology (eff 5/92)
```

```
                              93 = Emergency medicine (eff 5/92)
                              94 = Interventional radiology (eff 5/92)
                              95 = Independent physiological
                                   laboratory (eff 5/92)
                              96 = Optician (eff 10/93)
                              97 = Physician assistant (eff 5/92)
                              98 = Gynecologist/oncologist (eff 10/94)
                              99 = Unknown physician specialty
                              A0 = Hospital (eff 10/93) (DMERCs only)
                              A1 = SNF (eff 10/93) (DMERCs only)
                              A2 = Intermediate care nursing facility
                                   (eff 10/93) (DMERCs only)
                              A3 = Nursing facility, other (eff 10/93)
                                   (DMERCs only)
                              A4 = HHA (eff 10/93) (DMERCs only)
                              A5 = Pharmacy (eff 10/93) (DMERCs only)
                              A6 = Medical supply company with respiratory
                                   therapist (eff 10/93) (DMERCs only)
                              A7 = Department store (for DMERC use:
                                   eff 10/94, but cross-walked from
                                   code 87 eff 10/93)
                              A8 = Grocery store (for DMERC use:
                                   eff 10/94, but cross-walked from
```

```
1      HCFA_PRVDR_SPCLTY_TB                        HCFA Provider Specialty Table
       --------------------                        -----------------------------
```

```
                              code 88 eff 10/93)
```

```
1      HCFA_TYPE_SRVC_TB                           HCFA Type of Service Table
       -----------------                           --------------------------
```

```
                              1 = Medical care
                              2 = Surgery
                              3 = Consultation
                              4 = Diagnostic radiology
                              5 = Diagnostic laboratory
                              6 = Therapeutic radiology
                              7 = Anesthesia
                              8 = Assistant at surgery
                              9 = Other medical items or services
                              0 = whole blood only eff 01/96,
                                  whole blood or packed red cells before 01/96
                              A = Used durable medical equipment (DME)
```

```
             B = High risk screening mammography
                 (obsolete 1/1/98)
             C = Low risk screening mammography
                 (obsolete 1/1/98)
             D = Ambulance (eff 04/95)
             E = Enteral/parenteral nutrients/supplies
                 (eff 04/95)
             F = Ambulatory surgical center (facility
                 usage for surgical services)
             G = Immunosuppressive drugs
             H = Hospice services (discontinued 01/95)
             I = Purchase of DME (installment basis)
                 (discontinued 04/95)
             J = Diabetic shoes (eff 04/95)
             K = Hearing items and services (eff 04/95)
             L = ESRD supplies (eff 04/95)
                 (renal supplier in the home before 04/95)
             M = Monthly capitation payment for dialysis
             N = Kidney donor
             P = Lump sum purchase of DME, prosthetics,
                 orthotics
             Q = Vision items or services
             R = Rental of DME
             S = Surgical dressings or other medical supplies
                 (eff 04/95)
             T = Psychological therapy (term. 12/31/97)
                 outpatient mental health limitation (eff. 1/1/98)
             U = Occupational therapy
             V = Pneumococcal/flu vaccine (eff 01/96),
                 Pneumococcal/flu/hepatitis B vaccine (eff 04/95-12/95),
                 Pneumococcal only before 04/95
             W = Physical therapy
             Y = Second opinion on elective surgery
                 (obsoleted 1/97)
             Z = Third opinion on elective surgery
                 (obsoleted 1/97)
```

```
1 LINE_ADDTNL_CLM_DCMTN_IND_TB          Line Additional Claim Documentation Indicator Table
  ----------------------------          ---------------------------------------------------


             0 = No additional documentation
             1 = Additional documentation submitted for
                 non-DME EMC claim
```

```
      2 = CMN/prescription/other documentation submitted
          which justifies medical necessity
      3 = Prior authorization obtained and approved
      4 = Prior authorization requested but not approved
      5 = CMN/prescription/other documentation submitted
          but did not justify medical necessity
      6 = CMN/prescription/other documentation submitted
          and approved after prior authorization rejected
      7 = Recertification CMN/prescription/other
          documentation
```

1   LINE_PLC_SRVC_TB   Line Place Of Service Table
         ---------------   ---------------------------

                              Prior To 1/92

```
      1 = Office
      2 = Home
      3 = Inpatient hospital
      4 = SNF
      5 = Outpatient hospital
      6 = Independent lab
      7 = Other
      8 = Independent kidney disease treatment
          center
      9 = Ambulatory
      A = Ambulance service
      H = Hospice
      M = Mental health, rural mental health
      N = Nursing home
      R = Rural codes


          ----------------------------------------
                        **Effective 1/92**

     11 = Office
     12 = Home
     21 = Inpatient hospital
     22 = Outpatient hospital
     23 = Emergency room - hospital
     24 = Ambulatory surgical center
     25 = Birthing center
     26 = Military treatment facility
```

```
                           31 = Skilled nursing facility
                           32 = Nursing facility
                           33 = Custodial care facility
                           34 = Hospice
                           35 = Adult living care facilities (ALCF)
                                (eff. NYD - added 12/3/97)
                           41 = Ambulance - land
                           42 = Ambulance - air or water
                           50 = Federally qualified health centers
                                (eff. 10/1/93)
                           51 = Inpatient psychiatric facility
                           52 = Psychiatric facility partial hospitalization
                           53 = Community mental health center
                           54 = Intermediate care facility/mentally
                                retarded
                           55 = Residential substance abuse treatment
                                facility
                           56 = Psychiatric residential treatment
                                center
                           60 = Mass immunizations center (eff. 9/1/97)
                           61 = Comprehensive inpatient rehabilitation
                                facility
                           62 = Comprehensive outpatient rehabilitation
                                facility
                           65 = End stage renal disease treatment facility
                           71 = State or local public health clinic
                           72 = Rural health clinic
                           81 = Independent laboratory
```

1	LINE_PLC_SRVC_TB	Line Place Of Service Table
	----------------	-------------------------

```
                           99 = Other unlisted facility
```

1	LINE_PMT_IND_TB	Line Payment Indicator Table
	---------------	-------------------------

```
                           1 = Actual charge
                           2 = Customary charge
                           3 = Prevailing charge (adjusted, unadjusted
                               gap fill, etc)
                           4 = Other (ASC fees, radiology and
                               outpatient limits, and non-payment
                               because of denial.
```

```
              5 = Lab fee schedule
              6 = Physician fee schedule - full fee
                  schedule amount
              7 = Physician fee schedule - transition
              8 = Clinical psychologist fee schedule
              9 = DME and prosthetics/orthotics fee
                  schedules (eff. 4/97)
```

1   LINE_PRCSG_IND_TB   Line Processing Indicator Table
       ------------------   ------------------------------

```
              A = Allowed
              B = Benefits exhausted
              C = Noncovered care
              D = Denied (existed prior to 1991; from
                  BMAD)
              I = Invalid data
              L = CLIA (eff 9/92)
              M = Multiple submittal--duplicate line item
              N = Medically unnecessary
              O = Other
              P = Physician ownership denial (eff 3/92)
              Q = MSP cost avoided (contractor #88888) -
                  voluntary agreement (eff. 1/98)
              R = Reprocessed--adjustments based on
                  subsequent reprocessing of claim
              S = Secondary payer
              T = MSP cost avoided - IEQ contractor
                  (eff. 7/76)
              U = MSP cost avoided - HMO rate cell
                  adjustment (eff. 7/96)
              V = MSP cost avoided - litigation
                  settlement (eff. 7/96)
              X = MSP cost avoided - generic
              Y = MSP cost avoided - IRS/SSA data
                  match project
              Z = Bundled test, no payment
                  (eff. 1/1/98)
```

1 LINE_PRVDR_PRTCPTG_IND_TB   Line Provider Participating Indicator Table
   -------------------------   ---

                        1 = Participating
                        2 = All or some covered and allowed
                            expenses applied to deductible Participating
                        3 = Assignment accepted/non-participating
                        4 = Assignment not accepted/non-participating
                        5 = Assignment accepted but all or some
                            covered and allowed expenses applied
                            to deductible Non-participating.
                        6 = Assignment not accepted and all covered
                            and allowed expenses applied to deductible
                            non-participating.
                        7 = Participating provider not accepting
                            assignment.

1   NCH_CLM_TYPE_TB   NCH Claim Type Table
        ---------------   --------------------

                        10 = HHA claim
                        20 = Non swing bed SNF claim
                        30 = Swing bed SNF claim
                        40 = Outpatient claim
                        41 = Outpatient 'Full-Encounter' claim
                             (available in NMUD)
                        42 = Outpatient 'Abbreviated-Encounter' claim
                             (available in NMUD)
                        50 = Hospice claim
                        60 = Inpatient claim
                        61 = Inpatient 'Full-Encounter' claim
                        62 = Inpatient 'Abbreviated-Encounter claim
                             (available in NMUD)
                        71 = RIC O local carrier non-DMEPOS claim
                        72 = RIC O local carrier DMEPOS claim
                        73 = Physician 'Full-Encounter' claim
                             (available in NMUD)
                        81 = RIC M DMERC non-DMEPOS claim
                        82 = RIC M DMERC DMEPOS claim

1   NCH_EDIT_TB   NCH EDIT TABLE
        -----------   --------------

                        A0X1 = (C) PHYSICIAN-SUPPLIER ZIP CODE
                        A000 = (C) REIMB > $100,000 OR UNITS > 150

```
A002 = (C) CLAIM IDENTIFIER (CAN)
A003 = (C) BENEFICIARY IDENTIFICATION (BIC)
A004 = (C) PATIENT SURNAME BLANK
A005 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
A006 = (C) DATE OF BIRTH IS NOT NUMERIC
A007 = (C) INVALID GENDER (0, 1, 2)
A008 = (C) INVALID QUERY-CODE (WAS CORRECTED)
A025 = (C) FOR OV 4, TOB MUST = 13,83,85,73
A1X1 = (C) PERCENT ALLOWED INDICATOR
A1X2 = (C) DT>97273,DG1=7611,DG<>103,163,1589
A1X3 = (C) DT>96365,DIAG=V725
A1X4 = (C) INVALID DIAGNOSTIC CODES
C050 = (U) HOSPICE - SPELL VALUE INVALID
D102 = (C) DME DATE OF BIRTH INVALID
D2X2 = (C) DME SCREEN SAVINGS INVALID
D2X3 = (C) DME SCREEN RESULT INVALID
D2X4 = (C) DME DECISION IND INVALID
D2X5 = (C) DME WAIVER OF PROV LIAB INVALID
D3X1 = (C) DME NATIONAL DRUG CODE INVALID
D4X1 = (C) DME BENE RESIDNC STATE CODE INVALID
D4X2 = (C) DME OUT OF DMERC SERVICE AREA
D4X3 = (C) DME STATE CODE INVALID
D5X1 = (C) TOS INVALID FOR DME HCPCS
D5X2 = (C) DME HCPCS NOC & NOC DESCRIP MISSING
D5X3 = (C) DME INVALID USE OF MS MODIFIER
D5X4 = (C) TOS9 NDC REQD WHEN HCPCS OMITTED
D5X5 = (C) TOS9 NDC REQD FOR Q0127-130 HCPCS
D5X6 = (C) TOS9 NDC/DIAGNOSIS CODE INVALID
D6X1 = (C) DME SUPPLIER NUMBER MISSING
D7X1 = (C) DME PURCHASE ALLOWABLE INVALID
D919 = (C) CAPPED/PEN PUMPS,NUM OF SRVCS > 1
D921 = (C) SHOE HCPC W/O MOD RT,LT REQ U=2/4/6
XXXX = (D) SYS DUPL: HOST/BATCH/QUERY-CODE
Y001 = (C) HCPCS R0075/UNITS>1/SERVICES=1
Y002 = (C) HCPCS R0075/UNITS=1/SERVICES>1
Y003 = (C) HCPCS R0075/UNITS=SERVICES
Y010 = (C) TOB=13X/14X AND T.C.>$7,500
Y011 = (C) INP CLAIM/REIM > $75,000
Z001 = (C) RVNU 820-859 REQ COND CODE 71-76
Z002 = (C) CC M2 PRESENT/REIMB > $150,000
Z003 = (C) CC M2 PRESENT/UNITS > 150
Z004 = (C) CC M2 PRESENT/UNITS & REIM < MAX
Z005 = (C) REIMB>99999 AND REIMB<150000
Z006 = (C) UNITS>99 AND UNITS<150
```

```
                                       Z237 = (E) HOSPICE OVERLAP - DATE ZERO
                                       0011 = (C) ACTION CODE INVALID
                                       0013 = (C) CABG/PCOE AND INVALID ADMIT DATE
                                       0014 = (C) DEMO NUM NOT=01-06,08,15,31
                                       0015 = (C) ESRD PLAN BUT DEMO ID NOT = 15
                                       0016 = (C) INVALID VA CLAIM
                                       0017 = (C) DEMO=31,TOB<>11 OR SPEC<>08
                                       0018 = (C) DEMO=31,ACT CD<>1/5 OR ENT CD<>1/5
                                       0020 = (C) CANCEL ONLY CODE INVALID
                                       0021 = (C) DEMO COUNT > 1
                                       0301 = (C) INVALID HI CLAIM NUMBER
1         NCH_EDIT_TB                                         NCH EDIT TABLE
          -----------                                         --------------

                                       0302 = (C) BENE IDEN CDE (BIC) INVAL OR BLK
                                       04A1 = (C) PATIENT SURNAME BLANK (PHYS/SUP)
                                       04B1 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
                                       0401 = (C) BILL TYPE/PROVIDER INVALID
                                       0402 = (C) BILL TYPE/REV CODE/PROVR RANGE
                                       0406 = (C) MAMMOGRAPHY WITH NO HCPCS 76092
                                       0407 = (C) RESPITE CARE BILL TYPE 34X,NO REV 66
                                       0408 = (C) REV CODE 403 /TYPE 71X/ PROV3800-974
                                       0410 = (C) IMMUNO DRUG OCCR-36,NO REV-25 OR 636
                                       0412 = (C) BILL TYPE XX5 HAS ACCOM. REV. CODES
                                       0413 = (C) CABG/PCOE BUT TOB = HHA,OUT,HOS
                                       0414 = (C) VALU CD 61,MSA AMOUNT MISSING
                                       0415 = (C) HOME HEALTH INCORRECT ALPHA RIC
                                       05X4 = (C) UPIN REQUIRED FOR TYPE-OF-SERVICE
                                       05X5 = (C) UPIN REQUIRED FOR DME HCPCS
                                       0501 = (C) UNIQUE PHY IDEN. (UPIN) BLANK
                                       0502 = (C) UNIQUE PHY IDEN. (UPIN) INVALID
                                       0601 = (C) GENDER INVALID
                                       0701 = (C) CONTRACTOR INVALID CARRIER/ETC
                                       0702 = (C) PROVIDER NUMBER INCONSISTANT
                                       0703 = (C) MAMMOGRAPHY FOR NOT FEMALE
                                       0704 = (C) INVALID CONT FOR CABG DEMO
                                       0705 = (C) INVALID CONT FOR PCOE DEMO
                                       0901 = (C) INVALID DISP CODE OF 02
                                       0902 = (C) INVALID DISP CODE OF SPACES
                                       0903 = (C) INVALID DISP CODE
                                       1001 = (C) PROF REVIEW/ACT CODE/BILL TYPE
                                       13X2 = (C) MULTIPLE ITEMS FOR SAME SERVICE
                                       1301 = (C) LINE COUNT NOT NUMERIC OR > 13
                                       1302 = (C) RECORD LENGTH INVALID
```

```
                                      1401 = (C) INVALID MEDICARE STATUS CODE
                                      1501 = (C) ADMIT DATE/ENTRY CODE INVALID
                                      1502 = (C) ADMIT DATE > STAY FROM DATE
                                      1503 = (C) ADMIT DATE INVALID WITH THRU DATE
                                      1504 = (C) ADM/FROM/THRU DATE > TODAYS DATE
                                      1505 = (C) HCPCS W SERVICE DATES > 09-30-94
                                      1601 = (C) INVESTIGATION IND INVALID
                                      1701 = (C) SPLIT IND INVALID
                                      1801 = (C) PAY-DENY CODE INVALID
                                      1802 = (C) HEADER AMT AND NOT DENIED CLAIM
                                      1803 = (C) MSP COST AVD/ALL MSP LI NOT SAME
                                      1901 = (C) AB CROSSOVER IND INVALID
                                      2001 = (C) HOSPICE OVERRIDE INVALID
                                      2101 = (C) HMO-OVERRIDE/PATIENT-STAT INVALID
                                      2102 = (C) FROM/THRU DATE OR KRON/PAT STAT
                                      2201 = (C) FROM/THRU DATE OR HCPCS YR INVAL
                                      2202 = (C) STAY-FROM DATE > THRU-DATE
                                      2203 = (C) THRU DATE INVALID
                                      2204 = (C) FROM DATE BEFORE EFFECTIVE DATE
                                      2205 = (C) DATE YEARS DIFFERENT ON OUTPAT
                                      2207 = (C) MAMMOGRAPHY BEFORE 1991
                                      2301 = (C) DOCUMENT CNTL OR UTIL DYS INVALID
                                      2302 = (C) COVERED DAYS INVALID OR INCONSIST
                                      2303 = (C) COST REPORT DAYS > ACCOMIDATION
                                      2304 = (C) UTIL DAYS = ZERO ON PATIENT BILL
                                      2305 = (C) UTIL DAYS = INCONSISTENCIES
                                      2306 = (C) UTIL DYS/NOPAY/REIMB INCONSISTENT
                                      2307 = (C) COND=40,UTL DYS >0/VAL CDE A1,08,09
1           NCH_EDIT_TB                                 NCH EDIT TABLE
            -----------                                 --------------

                                      2308 = (C) NOPAY = R WHEN UTIL DAYS = ZERO
                                      2401 = (C) NON-UTIL DAYS INVALID
                                      2501 = (C) CLAIM RCV DT OR COINSURANCE INVAL
                                      2502 = (C) COIN+LR>UTIL DAYS/RCPT DTE>CUR DTE
                                      2503 = (C) COIN/TR TYP/UTIL DYS/RCPT DTE>PD/DEN
                                      2504 = (C) COINSURANCE AMOUNT EXCESSIVE
                                      2505 = (C) COINSURANCE RATE > ALLOWED AMOUNT
                                      2506 = (C) COINSURANCE DAYS/AMOUNT INCONSIST
                                      2507 = (C) COIN+LR DAYS > TOTAL DAYS FOR YR
                                      2508 = (C) COINSURANCE DAYS INVALID FOR TRAN
                                      2601 = (C) CLAIM PAID DT INVALID OR LIFE RES
                                      2602 = (C) LR-DYS, NO VAL 08,10/PD/DEN>CUR+27
                                      2603 = (C) LIFE RESERVE > RATE FOR CAL YEAR
```

```
2604 = (C) PPS BILL, NO DAY OUTLIER
2605 = (C) LIFE RESERVE RATE > DAILY RATE AVR.
28XA = (C) UTIL DAYS > FROM TO BENEF EXH
28XB = (C) BENEFITS EXH DATE > FROM DATE
28XC = (C) BENEFITS EXH DATE/INVALID TRANS TYPE
28XD = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP
28XE = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)
28XF = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)
28XG = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS
28XM = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE
28XN = (C) INVALID OCC CODE
28X0 = (C) BENE EXH DATE OUTSIDE SERVICE DATES
28X1 = (C) OCCUR DATE INVALID
28X2 = (C) OCCUR = 20 AND TRANS = 4
28X3 = (C) OCCUR 20 DATE < ADMIT DATE
28X4 = (C) OCCUR 20 DATE > ADMIT + 12
28X5 = (C) OCCUR 20 AND ADMIT NOT = FROM
28X6 = (C) OCCUR 20 DATE < BENE EXH DATE
28X7 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
28X8 = (C) OCCUR 22 DATE < FROM OR > THRU
28X9 = (C) UTIL > FROM - THRU LESS NCOV
33X1 = (C) QUAL STAY DATES INVALID (SPAN=70)
33X2 = (C) QS FROM DATE NOT < THRU (SPAN=70)
33X3 = (C) QS DAYS/ADMISSION ARE INVALID
33X4 = (C) QS THRU DATE > ADMIT DATE (SPAN=70)
33X5 = (C) SPAN 70 INVALID FOR DATE OF SERVICE
33X6 = (C) TOB=18/21/28/51,COND=WO,HMO<>90091
33X7 = (C) TOB<>18/21/28/51,COND=WO
33X8 = (C) TOB=18/21/28/51,CO=WO,ADM DT<97001
33X9 = (C) TOB=32X SPAN 70 OR OCCR BO PRESENT
34X2 = (C) DEMO ID = 04 AND COND WO NOT SHOWN
3401 = (C) DEMO ID = 04 AND RIC NOT = 1
35X1 = (C) 60, 61, 66 & NON-PPS / 65 & PPS
35X2 = (C) COND = 60 OR 61 AND NO VALU 17
35X3 = (C) PRO APPROVAL COND C3,C7 REQ SPAN M0
36X1 = (C) SURG DATE < STAY FROM/ > STAY THRU
3701 = (C) ASSIGN CODE INVALID
3705 = (C) 1ST CHAR OF IDE# IS NOT ALPHA
3706 = (C) INVALID IDE NUMBER-NOT IN FILE
3710 = (C) NUM OF IDE# > REV 0624
3715 = (C) NUM OF IDE# < REV 0624
3720 = (C) IDE AND LINE ITEM NUMBER > 2
3801 = (C) AMT BENE PD INVALID
4001 = (C) BLOOD PINTS FURNISHED INVALID
```

```
                                   4002 = (C) BLOOD FURNISHED/REPLACED INVALID
1          NCH_EDIT_TB                                 NCH EDIT TABLE
           -----------                                 --------------

                                   4003 = (C) BLOOD FURNISHED/VERIFIED/DEDUCT
                                   4201 = (C) BLOOD PINTS UNREPLACED INVALID
                                   4202 = (C) BLOOD PINTS UNREPLACED/BLOOD DED
                                   4203 = (C) INVALID CPO PROVIDER NUMBER
                                   4301 = (C) BLOOD DEDUCTABLE INVALID
                                   4302 = (C) BLOOD DEDUCT/FURNISHED PINTS
                                   4303 = (C) BLOOD DEDUCT > UNREPLACED BLOOD
                                   4304 = (C) BLOOD DEDUCT > 3 - REPLACED
                                   4501 = (C) PRIMARY DIAGNOSIS INVALID
                                   46XA = (C) MSP VET AND VET AT MEDICARE
                                   46XB = (C) MULTIPLE COIN VALU CODES (A2,B2,C2)
                                   46XC = (C) COIN VALUE (A2,B2,C2) ON INP/SNF
                                   46XG = (C) VALU CODE 20 INVALID
                                   46XN = (C) VALUE CODE 37,38,39 INVALID
                                   46XO = (C) VALUE CDE 38>0/VAL CDE 06 MISSNG
                                   46XP = (C) BLD UNREP VS REV CDS AND/OR UNITS
                                   46XQ = (C) VALUE CDE 37=39 AND 38 IS PRESENT
                                   46XR = (C) BLD FIELDS VS REV CDE 380,381,382
                                   46XS = (C) VALU CODE 39, AND 37 IS NOT PRESENT
                                   46XT = (C) CABG/PCOE,VC<>Y1,Y2,Y3,Y4,VA NOT>0
                                   46X1 = (C) VALUE AMOUNT INVALID
                                   46X2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO
                                   46X3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)
                                   46X4 = (C) VALU (A1,B1,C1): AMT > DEDUCT
                                   46X5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL
                                   46X6 = (C) VALU 17 AND NO COND CODE 60 OR 61
                                   46X7 = (C) OUTLIER(VAL 17) > REIMB + VAL6-16
                                   46X8 = (C) MULTI CASH DED VALU CODES (A1,B1,C1)
                                   46X9 = (C) DEMO ID=03,REQUIRED HCPCS NOT SHOWN
                                   4600 = (C) CAPITAL TOTAL NOT = CAP VALUES
                                   4601 = (C) CABG/PCOE, MSP CODE PRESENT
                                   4603 = (C) DEMO ID = 03 AND RIC NOT=6,7
                                   4901 = (C) PCOE/CABG,DEN CD NOT D
                                   4902 = (C) PCOE/CABG BUT DME
                                   50X1 = (C) RVCD=54,TOB<>13,23,32,33,34,83,85
                                   50X2 = (C) REV CD=054X,MOD NOT = QM,QN
                                   5051 = (E) EDB: NOMATCH ON 3 CHARACTERISTICS
                                   5052 = (E) EDB: NOMATCH ON MASTER-ID RECORD
                                   5053 = (E) EDB: NOMATCH ON CLAIM-NUMBER
                                   51XA = (C) HCPCS EYEWARE & REV CODE NOT 274
```

```
51XC = (C) HCPCS REQUIRES DIAG CODE OF CANCER
51XD = (C) HCPCS REQUIRES UNITS > ZERO
51XE = (C) HCPCS REQUIRES REVENUE CODE 636
51XF = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS
51XG = (C) HCPCS REQUIRES DIAG OF HEMOPHILL1A
51XH = (C) TOB 21X/P82=2/3/4;REV CD<9001,>9044
51XI = (C) TOB 21X/P82<>2/3/4:REV CD>8999<9045
51XJ = (C) TOB 21X/REV CD: SVC-FROM DT INVALID
51XK = (C) TOB 21X/P82=2/3/4,REV CD = NNX
51XL = (C) REV 0762/UNT>48,TOB NOT=12,13,85,83
51XM = (C) 21X,RC>9041/<9045,RC<>4/234
51XN = (C) 21X,RC>9032/<9042,RC<>4/234
51XP = (C) HHA RC DATE OF SRVC MISSING
51XQ = (C) NO RC 0636 OR DTE INVALID
51XR = (C) DEMO ID=01,RIC NOT=2
51XS = (C) DEMO ID=01,RUGS<>2,3,4 OR BILL<>21
51X0 = (C) REV CENTER CODE INVALID
51X1 = (C) REV CODE CHECK
```

1   NCH_EDIT_TB   NCH EDIT TABLE
        -----------   --------------

```
51X2 = (C) REV CODE INCOMPATIBLE BILL TYPE
51X3 = (C) UNITS MUST BE > 0
51X4 = (C) INP:CHGS/YR-RATE,ETC; OUTP:PSYCH>YR
51X5 = (C) REVENUE NON-COVERED > TOTAL CHRGE
51X6 = (C) REV TOTAL CHARGES EQUAL ZERO
51X7 = (C) REV CDE 403 WTH NO BILL 14 23 71 85
51X8 = (C) MAMMOGRAPHY SUBMISSION INVALID
51X9 = (C) HCPCS/REV CODE/BILL TYPE
5100 = (U) TRANSITION SPELL / SNF
5160 = (U) LATE CHG HSP BILL STAY DAYS > 0
5166 = (U) PROVIDER NE TO 1ST WORK PRVDR
5167 = (U) PROVIDER 1 NE 2: FROM DT < START DT
5169 = (U) PROVIDER NE TO WORK PROVIDER
5177 = (U) PROVIDER NE TO WORK PROVIDER
5178 = (U) HOSPICE BILL THRU < DOLBA
5181 = (U) HOSP BILL OCCR 27 DISCREPANCY
5200 = (E) ENTITLEMENT EFFECTIVE DATE
5201 = (U) HOSP DATE DIFFERENCE NE 60 OR 90
5202 = (E) ENTITLEMENT HOSPICE EFFECTIVE DATE
5202 = (U) HOSPICE TRAILER ERROR
5203 = (E) ENTITLEMENT HOSPICE PERIODS
5203 = (U) HOSPICE START DATE ERROR
5204 = (U) HOSPICE DATE DIFFERENCE NE 90
```

```
                            5205 = (U) HOSPICE DATE DISCREPANCY
                            5206 = (U) HOSPICE DATE DISCREPANCY
                            5207 = (U) HOSPICE THRU > TERM DATE 2ND
                            5208 = (U) HOSPICE PERIOD NUMBER BLANK
                            5209 = (U) HOSPICE DATE DISCREPANCY
                            5210 = (E) ENTITLEMENT FRM/TRU/END DATES
                            5211 = (E) ENTITLEMENT DATE DEATH/THRU
                            5212 = (E) ENTITLEMENT DATE DEATH/THRU
                            5213 = (E) ENTITLEMENT DATE DEATH MBR
                            5220 = (E) ENTITLEMENT FROM/EFF DATES
                            5225 = (E) ENT INP PPS SPAN 70 DATES
                            5232 = (E) ENTL HMO NO HMO OVERRIDE CDE
                            5233 = (E) ENTITLEMENT HMO PERIODS
                            5234 = (E) ENTITLEMENT HMO NUMBER NEEDED
                            5235 = (E) ENTITLEMENT HMO HOSP+NO CC07
                            5236 = (E) ENTITLEMENT HMO HOSP + CC07
                            5237 = (E) ENTITLEMENT HOSP OVERLAP
                            5238 = (U) HOSPICE CLAIM OVERLAP > 90
                            5239 = (U) HOSPICE CLAIM OVERLAP > 60
                            524Z = (E) HOSP OVERLAP NO OVD NO DEMO
                            5240 = (U) HOSPICE DAYS STAY+USED > 90
                            5241 = (U) HOSPICE DAYS STAY+USED > 60
                            5242 = (C) INVALID CARRIER FOR RRB
                            5243 = (C) HMO=90091,INVALID SERVICE DTE
                            5244 = (E) DEMO CABG/PCOE MISSING ENTL
                            5245 = (C) INVALID CARRIER FOR NON RRB
                            525Z = (E) HMO/HOSP 6/7 NO OVD NO DEMO
                            5250 = (U) HOSPICE DOEBA/DOLBA
                            5255 = (U) HOSPICE DAYS USED
                            5256 = (U) HOSPICE DAYS USED > 999
                            526Y = (E) HMO/HOSP DEMO 5/15 REIMB > 0
                            526Z = (E) HMO/HOSP DEMO 5/15 REIMB = 0
                            527Y = (E) HMO/HOSP DEMO OVD=1 REIMB > 0
                            527Z = (E) HMO/HOSP DEMO OVD=1 REIMB = 0
                            5299 = (U) HOSPICE PERIOD NUMBER ERROR
1         NCH_EDIT_TB                                        NCH EDIT TABLE
          -----------                                        --------------

                            5320 = (U) BILL > DOEBA AND IND-1 = 2
                            5350 = (U) HOSPICE DOEBA/DOLBA SECONDARY
                            5355 = (U) HOSPICE DAYS USED SECONDARY
                            5378 = (C) SERVICE DATE < AGE 50
                            5399 = (U) HOSPICE PERIOD NUM MATCH
                            5410 = (U) INPAT DEDUCTABLE
```

```
5425 = (U) PART B DEDUCTABLE CHECK
5430 = (U) PART B DEDUCTABLE CHECK
5450 = (U) PART B COMPARE MED EXPENSE
5460 = (U) PART B COMPARE MED EXPENSE
5499 = (U) MED EXPENSE TRAILER MISSING
5500 = (U) FULL DAYS/SNF-HOSP FULL DAYS
5510 = (U) COIN DAYS/SNF COIN DAYS
5515 = (U) FULL DAYS/COIN DAYS
5516 = (U) SNF FULL DAYS/SNF COIN DAYS
5520 = (U) LIFE RESERVE DAYS
5530 = (U) UTIL DAYS/LIFE PSYCH DAYS
5540 = (U) HH VISITS NE AFT PT B TRLR
5550 = (E) SNF LESS THAN PT A EFF DATE
5600 = (D) LOGICAL DUPE, COVERED
5601 = (D) LOGICAL DUPE, QRY-CDE, RIC 123
5602 = (D) LOGICAL DUPE, PANDE C, E OR I
5603 = (D) LOGICAL DUPE, COVERED
5605 = (D) POSS DUPE, OUTPAT REIMB
5606 = (D) POSS DUPE, HOME HEALTH COVERED U
5623 = (U) NON-PAY CODE IS P
57X1 = (C) PROVIDER SPECIALITY CODE INVALID
57X2 = (C) PHYS THERAPY/PROVIDER SPEC INVAL
57X3 = (C) PLACE/TYPE/SPECIALTY/REIMB IND
57X4 = (C) SPECIALTY CODE VS. HCPCS INVALID
5700 = (U) LINKED TO THREE SPELLS
5701 = (C) DEMO ID=02,RIC NOT = 5
5702 = (C) DEMO ID=02,INVALID PROVIDER NUM
58X1 = (C) PROVIDER TYPE INVALID
58X9 = (C) TYPE OF SERVICE INVALID
5802 = (C) REIMB > $150,000
5803 = (C) UNITS/VISITS > 150
5804 = (C) UNITS/VISITS > 99
59XA = (C) PROST ORTH HCPCS/FROM DATE
59XB = (C) HCPCS/FROM DATE/TYPE P OR I
59XC = (C) HCPCS Q0036,37,42,43,46/FROM DATE
59XD = (C) HCPCS Q0038-41/FROM DATE/TYPE
59XE = (C) HCPCS/MAMMOGRAPHY-RISK/ DIAGNOSIS
59XG = (C) CAPPED/FREQ-MAINT/PROST HCPCS
59XH = (C) HCPCS E0620/TYPE/DATE
59XI = (C) HCPCS E0627-9/ DATE < 1991
59XL = (C) HCPCS 00104 - TOS/POS
59X1 = (C) INVALID HCPCS/TOS COMBINATION
59X2 = (C) ASC IND/TYPE OF SERVICE INVALID
59X3 = (C) TOS INVALID TO MODIFIER
```

```
                             59X4 = (C) KIDNEY DONOR/TYPE/PLACE/REIMB
                             59X5 = (C) MAMMOGRAPHY FOR MALE
                             59X6 = (C) DRUG AND NON DRUG BILL LINE ITEMS
                             59X7 = (C) CAPPED-HCPCS/FROM DATE
                             59X8 = (C) FREQUENTLY MAINTAINED HCPCS
                             59X9 = (C) HCPCS E1220/FROM DATE/TYPE IS R
                             5901 = (U) ERROR CODE OF Q
                             60X1 = (C) ASSIGN IND INVALID
```

```
1           NCH_EDIT_TB                               NCH EDIT TABLE
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```

```
                             6000 = (U) ADJUSTMENT BILL SPELL DATA
                             6020 = (U) CURRENT SPELL DOEBA < 1990
                             6030 = (U) ADJUSTMENT BILL SPELL DATA
                             6035 = (U) ADJUSTMENT BILL THRU DTE/DOLBA
                             61X1 = (C) PAY PROCESS IND INVALID
                             61X2 = (C) DENIED CLAIM/NO DENIED LINE
                             61X3 = (C) PAY PROCESS IND/ALLOWED CHARGES
                             61X4 = (C) RATE MISSING OR NON-NUMERIC
                             6100 = (C) REV 0001 NOT PRESENT ON CLAIM
                             6101 = (C) REV COMPUTED CHARGES NOT=TOTAL
                             6102 = (C) REV COMPUTED NON-COVERED/NON-COV
                             6103 = (C) REV TOTAL CHARGES < PRIMARY PAYER
                             62XA = (C) PSYC OT PT/REIM/TYPE
                             62X1 = (C) DME/DATE/100% OR INVAL REIMB IND
                             62X6 = (C) RAD PATH/PLACE/TYPE/DATE/DED
                             62X8 = (C) KIDNEY DONO/TYPE/100%
                             62X9 = (C) PNEUM VACCINE/TYPE/100%
                             6201 = (C) TOTAL DEDUCT > CHARGES/NON-COV
                             6203 = (U) HOSPICE ADJUSTMENT PERIOD/DATE
                             6204 = (U) HOSPICE ADJUSTMENT THRU>DOLBA
                             6260 = (U) HOSPICE ADJUSTMENT STAY DAYS
                             6261 = (U) HOSPICE ADJUSTMENT DAYS USED
                             6265 = (U) HOSPICE ADJUSTMENT DAYS USED
                             6269 = (U) HOSPICE ADJUSTMENT PERIOD# (MAIN)
                             63X1 = (C) DEDUCT IND INVALID
                             63X2 = (C) DED/HCFA COINS IN PCOE/CABG
                             6365 = (U) HOSPICE ADJUSTMENT SECONDARY DAYS
                             6369 = (U) HOSPICE ADJUSTMENT PERIOD# (SECOND)
                             64X1 = (C) PROVIDER IND INVALID
                             6430 = (U) PART B DEDUCTABLE CHECK
                             65X1 = (C) PAYSCREEN IND INVALID
                             66?? = (D) POSS DUPE, CR/DB, DOC-ID
                             66XX = (D) POSS DUPE, CR/DB, DOC-ID
```

```
                      66X1 = (C) UNITS AMOUNT INVALID
                      66X2 = (C) UNITS IND > 0; AMT NOT VALID
                      66X3 = (C) UNITS IND = 0; AMT > 0
                      66X4 = (C) MT INDICATOR/AMOUNT
                      6600 = (U) ADJUSTMENT BILL FULL DAYS
                      6610 = (U) ADJUSTMENT BILL COIN DAYS
                      6620 = (U) ADJUSTMENT BILL LIFE RESERVE
                      6630 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
                      67X1 = (C) UNITS INDICATOR INVALID
                      67X2 = (C) CHG ALLOWED > 0; UNITS IND = 0
                      67X3 = (C) TOS/HCPCS=ANEST, MTU IND NOT = 2
                      67X4 = (C) HCPCS = AMBULANCE, MTU IND NOT = 1
                      67X6 = (C) INVALID PROC FOR MT IND 2, ANEST
                      67X7 = (C) INVALID UNITS IND WITH TOS OF BLOOD
                      67X8 = (C) INVALID PROC FOR MT IND 4, OXYGEN
                      6700 = (U) ADJUSTMENT BILL FULL/SNF DAYS
                      6710 = (U) ADJUSTMENT BILL COIN/SNF DAYS
                      68X1 = (C) INVALID HCPCS CODE
                      68X2 = (C) MAMMOGRAPY/DATE/PROC NOT 76092
                      68X3 = (C) TYPE OF SERVICE = G /PROC CODE
                      68X4 = (C) HCPCS NOT VALID FOR SERVICE DATE
                      68X5 = (C) MODIFIER NOT VALID FOR HCPCS, ETC
                      68X6 = (C) TYPE SERVICE INVALID FOR HCPCS, ETC
                      68X7 = (C) ZX MOD REQ FOR THER SHOES/INS/MOD.
                      68X8 = (C) LINE ITEM INCORRECT OR DATE INVAL.
1        NCH_EDIT_TB                               NCH EDIT TABLE
         -----------                               --------------

                      69XA = (C) MODIFIER NOT VALID FOR HCPCS/GLOBAL
                      69X3 = (C) PROC CODE MOD = LL / TYPE = R
                      69X6 = (C) PROC CODE MOD/NOT CAPPED
                      69X8 = (C) SPEC CODE NURSE PRACT, MOD INVAL
                      6901 = (C) KRON IND AND UTIL DYS EQUALS ZERO
                      6902 = (C) KRON IND AND NO-PAY CODE B OR N
                      6903 = (C) KRON IND AND INPATIENT DEDUCT = 0
                      6904 = (C) KRON IND AND TRANS CODE IS 4
                      6910 = (C) REV CODES ON HOME HEALTH
                      6911 = (C) REV CODE 274 ON OUTPAT AND HH ONLY
                      6912 = (C) REV CODE INVAL FOR PROSTH AND ORTHO
                      6913 = (C) REV CODE INVAL FOR OXYGEN
                      6914 = (C) REV CODE INVAL FOR DME
                      6915 = (C) PURCHASE OF RENT DME INVAL ON DATES
                      6916 = (C) PURCHASE OF RENT DME INVAL ON DATES
                      6917 = (C) PURCHASE OF LIFT CHAIR INVAL > 91000
```

```
6918 = (C) HCPCS INVALID ON DATE RANGES
6919 = (C) DME OXYGEN ON HH INVAL BEFORE 7/1/89
6920 = (C) HCPCS INVAL ON REV 270/BILL 32-33
6921 = (C) HCPCS ON REV CODE 272 BILL TYPE 83X
6922 = (C) HCPCS ON BILL TYPE 83X -NOT REV 274
6923 = (C) RENTAL OF DME CUSTOMIZE AND REV 291
6924 = (C) INVAL MODIFIER FOR CAPPED RENTAL
6925 = (C) HCPCS ALLOWED ON BILL TYPES 32X-34X
6929 = (U) ADJUSTMENT BILL LIFE RESERVE
6930 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
7000 = (U) INVALID DOEBA/DOLBA
7002 = (U) LESS THAN 60/61 BETWEEN SPELLS
7010 = (E) TOB 85X/ELECTN PRD: COND CD 07 REQD
71X1 = (C) SUBMITTED CHARGES INVALID
71X2 = (C) MAMMOGRPY/PROC CODE MOD TC,26/CHG
72X1 = (C) ALLOWED CHGS INVALID
72X2 = (C) ALLOWED/SUBMITTED CHARGES/TYPE
72X3 = (C) DENIED LINE/ALLOWED CHARGES
73X1 = (C) SS NUMBER INVALID
73X2 = (C) CARRIER ASSIGNED PROV NUM MISSING
74X1 = (C) LOCALITY CODE INVAL FOR CONTRACT
76X1 = (C) PL OF SER INVAL ON MAMMOGRAPHY BILL
77X1 = (C) PLACE OF SERVICE INVALID
77X2 = (C) PHYS THERAPY/PLACE
77X3 = (C) PHYS THERAPY/SPECIALTY/TYPE
77X4 = (C) ASC/TYPE/PLACE/REIMB IND/DED IND
77X6 = (C) TOS=F, PL OF SER NOT = 24
7701 = (C) INCORRECT MODIFIER
7777 = (D) POSS DUPE, PART B DOC-ID
78XA = (C) MAMMOGRAPHY BEFORE 1991
78X1 = (C) THRU DATE INVALID
78X3 = (C) FROM DATE GREATER THAN THRU DATE
78X4 = (C) FROM DATE > RCVD DATE/PAY-DENY
78X5 = (C) FROM DATE > PAID DATE/TYPE/100%
78X7 = (C) LAB EDIT/TYPE/100%/FROM DATE
79X3 = (C) THRU DATE>RECD DATE/NOT DENIED
79X4 = (C) THRU DATE>PAID DATE/NOT DENIED
8000 = (U) MAIN & 2NDARY DOEBA < 01/01/90
8028 = (E) NO ENTITLEMENT
8029 = (U) HH BEFORE PERIOD NOT PRESENT
8030 = (U) HH BILL VISITS > PT A REMAINING
8031 = (U) HH PT A REMAINING > 0
```

```
1       NCH_EDIT_TB                                      NCH EDIT TABLE
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```

```
8032 = (U) HH DOLBA+59 NOT GT FROM-DATE
8050 = (U) HH QUALIFYING INDICATOR = 1
8051 = (U) HH # VISITS NE AFT PT B APPLIED
8052 = (U) HH # VISITS NE AFT TRAILER
8053 = (U) HH BENEFIT PERIOD NOT PRESENT
8054 = (U) HH DOEBA/DOLBA NOT > 0
8060 = (U) HH QUALIFYING INDICATOR NE 1
8061 = (U) HH DATE NE DOLBA IN AFT TRLR
8062 = (U) HH NE PT-A VISITS REMAINING
81X1 = (C) NUM OF SERVICES INVALID
83X1 = (C) DIAGNOSIS INVALID
8301 = (C) HCPCS/GENDER DIAGNOSIS
8302 = (C) HCPCS G0101 V-CODE/SEX CODE
8304 = (C) BILL TYPE INVALID FOR G0123/4
84X1 = (C) PAP SMEAR/DIAGNOSIS/GENDER/PROC
84X2 = (C) INVALID DME START DATE
84X3 = (C) INVALID DME START DATE W/HCPCS
84X4 = (C) HCPCS G0101 V-CODE/SEX CODE
84X5 = (C) HCPCS CODE WITH INV DIAG CODE
86X8 = (C) CLIA REQUIRES NON-WAIVER HCPCS
88XX = (D) POSS DUPE, DOC-ID,UNITS,ENT,ALWD
9000 = (U) DOEBA/DOLBA CALC
9005 = (U) FULL/COINS HOSP DAYS CALC
9010 = (U) FULL/COINS SNF DAYS CALC
9015 = (U) LIFE RESERVE DAYS CALC
9020 = (U) LIFE PSYCH DAYS CALC
9030 = (U) INPAT DEDUCTABLE CALC
9040 = (U) DATA INDICATOR 1 SET
9050 = (U) DATA INDICATOR 2 SET
91X1 = (C) PATIENT REIMB/PAY-DENY CODE
92X1 = (C) PATIENT REIMB INVALID
92X2 = (C) PROVIDER REIMB INVALID
92X3 = (C) LINE DENIED/PATIENT-PROV REIMB
92X4 = (C) MSP CODE/AMT/DATE/ALLOWED CHARGES
92X5 = (C) CHARGES/REIMB AMT NOT CONSISTANT
92X7 = (C) REIMB/PAY-DENY INCONSISTANT
9201 = (C) UPIN REF NAME OR INITIAL MISSING
9202 = (C) UPIN REF FIRST 3 CHAR INVALID
9203 = (C) UPIN REF LAST 3 CHAR NOT NUMERIC
93X1 = (C) CASH DEDUCTABLE INVALID
93X2 = (C) DEDUCT INDICATOR/CASH DEDUCTIBLE
93X3 = (C) DENIED LINE/CASH DEDUCTIBLE
93X4 = (C) FROM DATE/CASH DEDUCTIBLE
```

```
              93X5 = (C) TYPE/CASH DEDUCTIBLE/ALLOWED CHGS
              9300 = (C) UPIN OTHER, NOT PRESENT
              9301 = (C) UPIN NME MIS/DED TOT LI>0 FR DEN CLM
              9302 = (C) UPIN OPERATING, FIRST 3 NOT NUMERIC
              9303 = (C) UPIN L 3 CH NT NUM/DED TOT LI>YR DED
              94A1 = (C) NON-COVERED FROM DATE INVALID
              94A2 = (C) NON-COVERED FROM > THRU DATE
              94A3 = (C) NON-COVERED THRU DATE INVALID
              94A4 = (C) NON-COVERED THRU DATE > ADMIT
              94A5 = (C) NON-COVERED THRU DATE/ADMIT DATE
              94C1 = (C) PR-PSYCH DAYS INVALID
              94C3 = (C) PR-PSYCH DAYS > PROVIDER LIMIT
              94F1 = (C) REIMBURSEMENT AMOUNT INVALID
              94F2 = (C) REIMBURSE AMT NOT 0 FOR HMO PAID
              94G1 = (C) NO-PAY CODE INVALID
```

1   NCH_EDIT_TB   NCH EDIT TABLE
           -----------   --------------

```
              94G2 = (C) NO-PAY CODE SPACE/NON-COVERD=TOTL
              94G3 = (C) NO-PAY/PROVIDER INCONSISTANT
              94G4 = (C) NO PAY CODE = R & REIMB PRESENT
              94X1 = (C) BLOOD LIMIT INVALID
              94X2 = (C) TYPE/BLOOD DEDUCTIBLE
              94X3 = (C) TYPE/DATE/LIMIT AMOUNT
              94X4 = (C) BLOOD DED/TYPE/NUMBER OF SERVICES
              94X5 = (C) BLOOD/MSP CODE/COMPUTED LINE MAX
              9401 = (C) BLOOD DEDUCTIBLE AMT > 3
              9402 = (C) BLOOD FURNISHED > DEDUCTIBLE
              9403 = (C) DATE OF BIRTH MISSING ON PRO-PAY
              9404 = (C) INVALID GENDER CODE ON PRO-PAY
              9407 = (C) INVALID DRG NUMBER
              9408 = (C) INVALID DRG NUMBER (GLOBAL)
              9409 = (C) HCFA DRG<>DRG ON BILL
              9410 = (C) CABG/PCOE,INVALID DRG
              95X1 = (C) MSP CODE G/DATE BEFORE 1/1/87
              95X2 = (C) MSP AMOUNT APPLIED INVALID
              95X3 = (C) MSP AMOUNT APPLIED > SUB CHARGES
              95X4 = (C) MSP PRIMARY PAY/AMOUNT/CODE/DATE
              95X5 = (C) MSP CODE = G/DATE BEFORE 1987
              95X6 = (C) MSP CODE = X AND NOT AVOIDED
              95X7 = (C) MSP CODE VALID, CABG/PCOE
              96X1 = (C) OTHER AMOUNTS INVALID
              96X2 = (C) OTHER AMOUNTS > PAT-PROV REIMB
              97X1 = (C) OTHER AMOUNTS INDICATOR INVALID
```

```
97X2 = (C) GRUDMAN SW/GRUDMAN AMT NOT > 0
98X1 = (C) COINSURANCE INVALID
98X3 = (C) MSP CODE/TYPE/COIN AMT/ALLOW/CSH
98X4 = (C) DATE/MSP/TYPE/CASH DED/ALLOW/COI
98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSP/TYP
99XX = (D) POSS DUPE, PART B DOC-ID
9901 = (C) REV CODE INVALID OR TRAILER CNT=0
9902 = (C) ACCOMMODATION DAYS/FROM/THRU DATE
9903 = (C) NO CLINIC VISITS FOR RHC
9904 = (C) INCOMPATIBLE DATES/CLAIM TYPE
991X = (C) NO DATE OF SERVICE
9910 = (C) EDIT 9910 (NEW)
9911 = (C) BLOOD VERIFIED INVALID
9920 = (C) EDIT 9920 (NEW)
9930 = (C) EDIT 9930 (NEW)
9931 = (C) OUTPAT COINSURANCE VALUES
9933 = (C) RATE EXCEDES MAMMOGRAPHY LIMIT
9940 = (C) EDIT 9940 (NEW)
9942 = (C) EDIT 9942 (NEW)
9944 = (C) STAY FROM>97273,DIAG<>V103,163,7612
9945 = (C) SERVICE DATE < 98001
9946 = (C) INVALID DIAGNOSIS CODE
9947 = (C) INVALID DIAGNOSIS CODE
9948 = (C) STAY FROM>96365,DIAG=V725
9960 = (C) MED CHOICE BUT HMO DATA MISSING
9965 = (C) HMO PRESENT BUT MED CHOICE MISSING
9968 = (C) MED CHOICE NOT= HMO PLAN NUMBER
```

```
1   NCH_IP_PRO_APRVL_TYPE_TB          NCH Inpatient Peer Review Organization Approval Type Table
    ------------------------          ---------------------------------------------------------
```

```
1 = Approved by the PRO as billed - Code
    indicates that the claim has been
    reviewed by the PRO and has been fully
    approved including any day or cost
    outliers.
2 = Automatic approval - Does not apply to
    Medicare claim.
3 = Partial approval - Code indicates the
    bill has been reviewed by the PRO, and
    some portion (days or services) has
    been denied.  The from/thru dates of
    the approved portion of the stay,
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                          excluding grace days and any period at
                          a noncovered level of care are shown
                          on the bill.
                      4 = Admission denied - Code indicates the
                          patient's need for inpatient services
                          was reviewed upon admission and the
                          PRO found that the stay was not
                          medically necessary.
                      5 = Post payment review - Code indicates
                          that any medical review will be
                          completed after the claim is paid.
                          The bill may be a day outlier, part of
                          the sample review, or may not be
                          reviewed.
                      6 = Pre-admission authorization - Pre-
                          admission authorization obtained, but
                          services not reviewed by the PRO.
                      7 THRU 9 = Reserved.


1      NCH_NEAR_LINE_RIC_TB               NCH Near-Line Record Identification Code Table
       --------------------               ---------------------------------------------



                      O = Part B physician/supplier claim
                          record (processed by local carriers;
                          can include DMEPOS services)
                      V = Part A institutional claim record
                          (inpatient (IP), skilled nursing
                          facility (SNF), christian science
                          (CS), home health agency (HHA), or
                          hospice)
                      W = Part B institutional claim record
                          (outpatient (OP), HHA)
                      U = Both Part A and B institutional home
                          health agency (HHA) claim records --
                          due to HHPPS and HHA A/B split.
                          (effective 10/00)
                      M = Part B DMEPOS claim record (processed
                          by DME Regional Carrier) (effective 10/93)


1      NCH_PATCH_TB                                NCH Patch Table
       ------------                                ---------------
```

01 = RRB Category Equatable BIC - changed (all
     claim types) -- applied during the Nearline
     'G' conversion to claims with NCH weekly
     process date before 3/91.   Prior to Version
     'H', patch indicator stored in redefined Claim
     Edit Group, 3rd occurrence, position 2.
02 = Claim Transaction Code made consistent with
     NCH payment/edit RIC code (OP and HHA) --
     effective 3/94, CWFMQA began patch. During
     'H' conversion, patch applied to claims with
     NCH weekly process date prior to 3/94. Prior
     to version 'H', patch indicator stored in
     redefined Claim Edit Group, 4th occurrence,
     position 1.
03 = Garbage/nonnumeric Claim Total Charge Amount
     set to zeroes (Instnl) -- during the Version
     'G' conversion, error occurred in the deriva-
     tion of this field where the claim was missing
     revenue center code = '0001'.   In 1994, patch
     was applied to the OP and HHA SAFs only. (This
     SAF patch indicator was stored in the redefined
     Claim Edit Group, 4th occurrence, position 2).
     During the 'H' ocnversion, patch applied to
     Nearline claims where garbage or nonnumeric
     values.
04 = Incorrect bene residence SSA standard county
     code '999' changed (all claim types) --
     applied during the Nearline 'G' conversion and
     ongoing through 4/21/94, calling EQSTZIP
     routine to claims with NCH weekly process
     date prior to 4/22/94. Prior to Version 'H'
     patch indicator stored in redefined Claim
     Edit Group, 3rd occurrence, position 4.
05 = Wrong century bene birth date corrected (all
     claim types) -- applied during Nearline 'H'
     conversion to all history where century
     greater than 1700 and less than 1850; if
     century less than 1700, zeroes moved.
06 = Inconsistent CWF bene medicare status code
     made consistent with age (all claim types) --
     applied during Nearline 'H' conversion to all
     history and patched ongoing. Bene age is
     calculated to determine the correct value;
     if greater than 64, 1st position MSC ='1';

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                         if less than 65, 1st position MSC = '2'.
                    07 = Missing CWF bene mediare status code derived
                         (all claim types) -- applied during Nearline
                         'H' conversion to all history and patched
                         ongoing, except claims with unknown DOB and/
                         or Claim From Date='0' (left blank).   Bene
                         age is calculated to determine missing value;
                         if greater than 64, MSC='10'; if less than
                         65, MSC = '20'.
                    08 = Invalid NCH primary payer code set to blanks
                         (Instnl) -- applied during Version 'H' con-
                         version to claims with NCH weekly process
                         date 10/1/93-10/30/95, where MSP values =
```

1   NCH_PATCH_TB   NCH Patch Table
           ------------   ---------------

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                         invalid '0', '1', '2', '3' or '4' (caused
                         by erroneous logic in HCFA program code,
                         which was corrected on 11/1/95).
                    09 = Zero CWF claim accretion date replaced with
                         NCH weekly process date (all claim types)
                         -- applied during Version 'H' conversion to
                         Instnl and DMERC claims; applied during
                         Version 'G' conversion to non-institutional
                         (non-DMERC) claims.  Prior to Version 'H',
                         patch indicator stored in redefined claim
                         edit group, 3rd occurrence, position 1.
                    10 = Multiple Revenue Center 0001 (Outpatient,
                         HHA and Hospice) -- patch applied to 1998 &
                         1999 Nearline and SAFs to delete any revenue
                         codes that followed the first '0001' revenue
                         center code.   The edit was applied across all
                         institutional claim types, including Inpatient/
                         SNF (the problem was only found with OP/HHA/
                         Hospice claims).  The problem was corrected
                         6/25/99.
                    11 = Truncated claim total charge amount in the
                         fixed portion replaced with the total charge
                         amount in the revenue center 0001 amount field
                         -- service years 1998 & 1999 patched during
                         quarterly merge.  The 1998 & 1999 SAFs were
                         corrected when finalized in 7/99.  The patch
                         was done for records with NCH Daily Process
                         Date 1/4/99 - 5/14/99.
```

```
12 = Missing claim-level HHA Total Visit Count --
     service years 1998, 1999 & 2000 patch applied
     during Version 'I' conversion of both the
     Nearline and SAFs.    Problem occurs in those
     claims recovered during the missing claims
     effect.
13 = Inconsistent Claim MCO Paid Switch made consistent
     with criteria used to identify an inpatient
     encounter claim -- if MCO paid switch equal to blank
     or '0' and ALL conditions are met to indicate an
     inpatient encounter claim (bene enrolled in a risk
     MCO during the service period), change the switch to
     a '1'.  The patch was applied during the Version 'I'
     conversion, for claims back to 7/1/97 service thru date.
```

```
1      NCH_STATE_SGMT_TB                                NCH State Segment Table
       -----------------                               -----------------------


                              01 = Alabama
                              02 = Alaska
                              03 = Arizona
                              04 = Arkansas
                              05 = California
                              06 = Colorado
                              07 = Connecticut
                              08 = Delaware
                              09 = District of Columbia
                              10 = Florida
                              11 = Georgia
                              12 = Hawaii
                              13 = Idaho
                              14 = Illinois
                              15 = Indiana
                              16 = Iowa
                              17 = Kansas
                              18 = Kentucky
                              19 = Louisiana
                              20 = Maine
                              21 = Maryland
                              22 = Massachusetts
                              23 = Michigan
                              24 = Minnesota
                              25 = Mississippi
```

```
                             26 = Missouri
                             27 = Montana
                             28 = Nebraska
                             29 = Nevada
                             30 = New Hampshire
                             31 = New Jersey
                             32 = New Mexico
                             33 = New York
                             34 = North Carolina
                             35 = North Dakota
                             36 = Ohio
                             37 = Oklahoma
                             38 = Oregon
                             39 = Pennsylvania
                             40 = Puerto Rico
                             41 = Rhode Island
                             42 = South Carolina
                             43 = South Dakota
                             44 = Tennesee
                             45 = Texas
                             46 = Utah
                             47 = Vermont
                             48 = Virgin Islands
                             49 = Virginia
                             50 = Washington
                             51 = West Virginia
                             52 = Wisconsin
                             53 = Wyoming
                             54 = Africa
                             55 = Asia
                             56 = Canada
                             57 = Central America & West Indies
1     NCH_STATE_SGMT_TB                         NCH State Segment Table
      -----------------                         -----------------------

                             58 = Europe
                             59 = Mexico
                             60 = Oceania
                             61 = Philippines
                             62 = South America
                             63 = US Possessions
                             97 = Saipan - MP
                             98 = Guam
                             99 = American Samoa
```

1   PRVDR_NUM_TB   Provider Number Table
       ------------   --------------------

              -   First two positions are the GEO SSA State Code.
                   Exception: 55 = California
                             67 = Texas
                             68 = Florida

              -   Positions 3 and sometimes 4 are used as a
                  category identifier. The remaining positions
                  are serial numbers. The following blocks of numbers
                  are reserved for the facilities indicated (NOTE:
                  may have different meanings dependent on the Type
                  of Bill (TOB):

                  0001-0879   Short-term (general and specialty)
                               hospitals where TOB = 11X; ESRD
                               clinic where TOB = 72X
                  0880-0899   Reserved for hospitals participating
                               in ORD demonstration projects where
                               TOB = 11X; ESRD clinic where TOB =
                               72X
                  0900-0999   Multiple hospital component in a
                               medical complex (numbers retired)
                               where TOB = 11X; ESRD clinic where
                               TOB = 72X
                  1000-1199   Reserved for future use
                  1200-1224   Alcohol/drug hospitals (excluded
                               from PPS-numbers retired)
                               where TOB = 11X; ESRD clinic where
                               TOB = 72X
                  1225-1299   Medical assistance facilities
                               (Montana project); ESRD clinic where
                               TOB = 72X
                  1300-1399   Rural Primary Care Hospital (RCPH) -
                               eff. 10/97 changed to Critical Access
                               Hospitals (CAH)
                  1400-1499   Continuation of 4900-4999 series (CMHC)
                  1500-1799   Hospices
                  1800-1989   Federally Qualified Health Centers
                               (FQHC) where TOB = 73X; SNF (IP PTB)
                               where TOB = 22X; HHA where TOB = 32X,

```
                         33X, 34X
          1990-1999     Christian Science Sanatoria
                         (hospital services)
          2000-2299     Long-term hospitals (excluded from PPS)
          2300-2499     Chronic renal disease facilities
                         (hospital based)
          2500-2899     Non-hospital renal disease
                         treatment centers
          2900-2999     Independent special purpose renal
                         dialysis facility (1)
          3000-3024     Formerly tuberculosis hospitals
                         (numbers retired)
          3025-3099     Rehabilitation hospitals (excluded
                         from PPS)
          3100-3199     Continuation of Subunits of Nonprofit
                         and Proprietary Home Health Agencies
                         (7300-7399) Series (3) (eff. 4/96)
          3200-3299     Continuation of 4800-4899 series (CORF)
```

```
1        PRVDR_NUM_TB                  Provider Number Table
         ------------                  --------------------
```

```
          3300-3399     Children's hospitals (excluded from PPS)
                         where TOB = 11X; ESRD clinic where TOB =
                         72X
          3400-3499     Continuation of rural health clinics
                         (provider-based) (3975-3999)
          3500-3699     Renal disease treatment centers
                         (hospital satellites)
          3700-3799     Hospital based special purpose renal
                         dialysis facility (1)
          3800-3974     Rural health clinics (free-standing)
          3975-3999     Rural health clinics (provider-based)
          4000-4499     Psychiatric hospitals (excluded
                         from PPS)
          4500-4599     Comprehensive Outpatient
                         Rehabilitation Facilities (CORF)
          4600-4799     Community Mental Health Centers (CMHC);
                         9/30/91 - 3/31/97 used for clinic OPT
                         where TOB = 74X
          4800-4899     Continuation of 4500-4599 series (CORF)
                          (eff. 10/95)
          4900-4999     Continuation of 4600-4799 series (CMHC)
                         (eff. 10/95); 9/30/91 - 3/31/97 used for
                         clinic OPT where TOB = 74X
```

```
5000-6499   Skilled Nursing Facilities
6500-6989   CMHC / Outpatient physical therapy services
            where TOB = 74X; CORF where TOB =
            75X
6990-6999   Christian Science Sanatoria (skilled
            nursing services)
7000-7299   Home Health Agencies (HHA) (2)
7300-7399   Subunits of 'nonprofit' and
            'proprietary' Home Health Agencies (3)
7400-7799   Continuation of 7000-7299 series
7800-7999   Subunits of state and local governmental
            Home Health Agencies (3)
8000-8499   Continuation of 7400-7799 series (HHA)
8500-8899   Continuation of rural health
            center (provider based) (3400-3499)
8900-8999   Continuation of rural health
            center (free-standing) (3800-3974)
9000-9499   Continuation of 8000-8499 series (HHA)
            (eff. 10/95)
9500-9999   Reserved for future use (eff. 8/1/98)
            NOTE: 10/95-7/98 this series was
            assigned to HHA's but rescinded - no
            HHA's were ever assigned a number
            from this series.
```

Exception:

```
P001-P999   Organ procurement organization
```

(1) These facilities (SPRDFS) will be assigned
    the same provider number whenever they
    are recertified.

(2) The 6400-6499 series of provider numbers
    in Iowa (16), South Dakota (43) and Texas (45)

have been used in reducing acute care costs (RACC)
experiments.

(3) In Virginia (49), the series 7100-7299 has
    been reserved for statewide subunit components
    of the Virginia state home health agencies.

        (4) Parent agency must have a number in the
            7000-7299, 7400-7799 or 8000-8499 series.

     NOTE:
       There is a special numbering system for units
       of hospitals that are excluded from prospective
       payment system (PPS) and hospitals with SNF
       swing-bed designation. An alpha character in
       the third position of the provider number
       identifies the type of unit or swing-bed
       designation as follows:

         S = Psychiatric unit (excluded from PPS)
         T = Rehabilitation unit (excluded from PPS)
         U = Short term/acute care swing-bed hospital
         V = Alcohol drug unit (prior to 10/87 only)
         W = Long term SNF swing-bed hospital
             (eff 3/91)
         Y = Rehab hospital swing-bed (eff 9/92)
         Z = Rural primary care swing-bed hospital

       There is also a special numbering system for
       assigning emergency hospital identification
       numbers (non participating hospitals). The
       sixth position of the provider number is as
       follows:

         E = Non-federal emergency hospital
         F = Federal emergency hospital

1   PTNT_DSCHRG_STUS_TB   Patient Discharge Status Table
       -------------------   -----------------------------

        01 = Discharged to home/self care (routine
             charge).
        02 = Discharged/transferred to other short term
             general hospital for inpatient care.
        03 = Discharged/transferred to skilled
             nursing facility (SNF) - (For hospitals
             with an approved swing bed arrangement,
             use Code 61 - swing bed. For reporting
             discharges/transfers to a non-certified

            SNF, the hospital must use Code 04 - ICF.
04 = Discharged/transferred to intermediate
        care facility (ICF).
05 = Discharged/transferred to another type
        of institution for inpatient care (including
        distinct parts).
06 = Discharged/transferred to home care of
        organized home health service organization.
07 = Left against medical advice or discontinued
        care.
08 = Discharged/transferred to home under
        care of a home IV drug therapy provider.
09 = Admitted as an inpatient to this
        hospital (effective 3/1/91). In situa-
        tions where a patient is admitted before
        midnight of the third day following the
        day of an outpatient service, the out-
        patient services are considered inpatient.
20 = Expired (did not recover - Christian
        Science patient).
30 = Still patient.
40 = Expired at home (hospice claims only)
41 = Expired in a medical facility such as
        hospital, SNF, ICF, or freestanding
        hospice. (Hospice claims only)
42 = Expired - place unknown (Hospice claims
        only)
50 = Hospice - home (eff. 10/96)
51 = Hospice - medical facility (eff. 10/96)
61 = Discharged/transferred within this insti-
        tution to a hospital-based Medicare
        approved swing bed (to be implemented in
        1999)
71 = Discharged/transferred/referred to another
        institution for outpatient services as
        specified by the discharge plan of care (to
        be implemented in 1999).
72 = Discharged/transferred/referred to this
        institution for outpatient services as
        specified by the discharge plan of care
        (to be implemented in 1999).

1   REV_CNTR_ANSI_TB   Revenue Center ANSI Code Table
       ----------------   ------------------------------

                                                Page 269

*******EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES*******
**************POSITIONS 1 & 2 OF ANSI CODE***************
CO = Contractual Obligations -- this group code should
     be used when a contractual agreement between the
     payer and payee, or a regulatory requirement, re-
     sulted in an adjustment. Generally, these adjust-
     ments are considered a write-off for the provider
     and are not billed to the patient.

CR = Corrections and Reversals -- this group code should
     be used for correcting a prior claim. It applies
     when there is a change to a previously adjudicated
     claim.

OA = Other Adjustments -- this group code should be used
     when no other group code applies to the adjustment.

PI = Payer Initiated Reductions -- this group code should
     be used when, in the opinion of the payer, the adjust-
     ment is not the responsibility of the patient, but
     there is no supporting contract between the provider
     and the payer (i.e., medical review or professional
     review organization adjustments).

PR = Patient Responsibility -- this group should be used
     when the adjustment represents an amount that should
     be billed to the patient or insured. This group
     would typically be used for deductible and copay
     adjustments.

************Claim Adjustment Reason Codes***************
***********POSITIONS 3 through 5 of ANSI CODE**********

1 = Deductible Amount
2 = Coinsurance Amount
3 = Co-pay Amount
4 = The procedure code is inconsistent with the modifier
    used or a required modifier is missing.
5 = The procedure code/bill type is inconsistent with the
    place of service.
6 = The procedure code is inconsistent with the patient's
    age.

```
                7 = The procedure code is inconsistent with the patient's
                    gender.
                8 = The procedure code is inconsistent with the provider
                    type.
                9 = The diagnosis is inconsistent with the patient's age.
               10 = The diagnosis is inconsistent with the patient's
                    gender.
               11 = The diagnosis is inconsistent with the procedure.
               12 = The diagnosis is inconsistent with the provider type.
               13 = the date of death precedes the date of service.
               14 = The date of birth follows the date of service.
               15 = Claim/service adjusted because the submitted auth-
                    orization number is missing, invalid, or does not
                    apply to the billed services or provider.
               16 = Claim/service lacks information which is needed for
```

```
1       REV_CNTR_ANSI_TB                        Revenue Center ANSI Code Table
        ----------------                        -----------------------------
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                    adjudication.
               17 = Claim/service adjusted because requested information
                    was not provided or was insufficient/incomplete.
               18 = Duplicate claim/service.
               19 = Claim denied because this is a work-related injury/
                    illness and thus the liability of the Worker's Com-
                    pensation Carrier.
               20 = Claim denied because this injury/illness is covered
                    by the liability carrier.
               21 = Claim denied because this injury/illness is the
                    liability of the no-fault carrier.
               22 = Claim adjusted because this care may be covered by
                    another payer per coordination of benefits.
               23 = Claim adjusted because charges have been paid by
                    another payer.
               24 = Payment for charges adjusted.  Charges are covered
                    under a capitation agreement/managed care plan.
               25 = Payment denied.  Your Stop loss deductible has not
                    been met.
               26 = Expenses incurred prior to coverage.
               27 = Expenses incurred after coverage terminated.
               28 = Coverage not in effect at the time the service was
                    provided.
               29 = The time limit for filing has expired.
               30 = Claim/service adjusted because the patient has not met
                    the required eligibility, spend down, waiting, or
```

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                 residency requirements.
          31 = Claim denied as patient cannot be identified as our
                 insured.
          32 = Our records indicate that this dependent is not an
                 eligible dependent as defined.
          33 = Claim denied.  Insured has no dependent coverage.
          34 = Claim denied.  Insured has no coverage for newborns.
          35 = Benefit maximum has been reached.
          36 = Balance does not exceed copayment amount.
          37 = Balance does not exceed deductible amount.
          38 = Services not provided or authorized by designated
                 (network) providers.
          39 = Services denied at the time authorization/pre-certi-
                 fication was requested.
          40 = Charges do not meet qualifications for emergency/urgent
                 care.
          41 = Discount agreed to in Preferred Provider contract.
          42 = Charges exceed our fee schedule or maximum allowable
                 amount.
          43 = Gramm-Rudman reduction.
          44 = Prompt-pay discount.
          45 = Charges exceed your contracted/legislated fee arrange-
                 ment.
          46 = This (these) service(s) is(are) not covered.
          47 = This (these) diagnosis(es) is(are) not covered,
                 missing, or are invalid.
          48 = This (these) procedure(s) is(are) not covered.
          49 = These are non-covered services because this is a
                 routine exam or screening procedure done in conjunc-
                 tion with a routine exam.
          50 = These are non-covered services because this is not
                 deemed a 'medical necessity' by the payer.
```

```
1      REV_CNTR_ANSI_TB                      Revenue Center ANSI Code Table
       ----------------                      -----------------------------
```

```
          51 = These are non-covered services because this a pre-
                 existing condition.
          52 = The referring/prescribing/rendering provider is not
                 eligible to refer/prescribe/order/perform the service
                 billed.
          53 = Services by an immediate relative or a member of the
                 same household are not covered.
          54 = Multiple physicians/assistants are not covered in this
                 case.
```

55 = Claim/service denied because procedure/treatment is
     deemed experimental/investigational by the payer.
56 = Claim/service denied because procedure/treatment has
     not been deemed 'proven to be effective' by payer.
57 = Claim/service adjusted because the payer deems the
     information submitted does not support this level of
     service, this many services, this length of service, or
     this dosage.
58 = Claim/service adjusted because treatment was deemed by
     the payer to have been rendered in an inappropriate
     or invalid place of service.
59 = Charges are adjusted based on multiple surgery rules or
     concurrent anesthesia rules.
60 = Charges for outpatient services with the proximity to
     inpatient services are not covered.
61 = Charges adjusted as penalty for failure to obtain second
     surgical opinion.
62 = Claim/service denied/reduced for absence of, or exceeded,
     precertification/authorization.
63 = Correction to a prior claim. INACTIVE
64 = Denial reversed per Medical Review. INACTIVE
65 = Procedure code was incorrect. This payment reflects the
     correct code. INACTIVE
66 = Blood Deductible.
67 = Lifetime reserve days. INACTIVE
68 = DRG weight. INACTIVE
69 = Day outlier amount.
70 = Cost outlier amount.
71 = Primary Payer amount.
72 = Coinsurance day. INACTIVE
73 = Administrative days. INACTIVE
74 = Indirect Medical Education Adjustment.
75 = Direct Medical Education Adjustment.
76 = Disproportionate Share Adjustment.
77 = Covered days. INACTIVE
78 = Non-covered days/room charge adjustment.
79 = Cost report days. INACTIVE
80 = Outlier days. INACTIVE
81 = Discharges. INACTIVE
82 = PIP days. INACTIVE
83 = Total visits. INACTIVE
84 = Capital adjustments. INACTIVE
85 = Interest amount. INACTIVE
86 = Statutory adjustment. INACTIVE

```
                              87 = Transfer amounts.
                              88 = Adjustment amount represents collection against
                                   receivable created in prior overpayment.
                              89 = Professional fees removed from charges.
                              90 = Ingredient cost adjustment.
1        REV_CNTR_ANSI_TB                     Revenue Center ANSI Code Table
         ----------------                     ------------------------------

                              91 = Dispensing fee adjustment.
                              92 = Claim paid in full. INACTIVE
                              93 = No claim level adjustment. INACTIVE
                              94 = Process in excess of charges.
                              95 = Benefits adjusted.  Plan procedures not followed.
                              96 = Non-covered charges.
                              97 = Payment is included in allowance for another
                                   service/procedure.
                              98 = The hospital must file the Medicare claim for this
                                   inpatient non-physician service. INACTIVE
                              99 = Medicare Secondary Payer Adjustment Amount. INACTIVE
                             100 = Payment made to patient/insured/responsible party.
                             101 = Predetermination: anticipated payment upon comple-
                                   tion of services or claim ajudication.
                             102 = Major medical adjustment.
                             103 = Provider promotional discount (i.e. Senior citizen
                                   discount).
                             104 = Managed care withholding.
                             105 = Tax withholding.
                             106 = Patient payment option/election not in effect.
                             107 = Claim/service denied because the related or qualifying
                                   claim/service was not paid or identified on the claim.
                             108 = Claim/service reduced because rent/purchase guidelines
                                   were not met.
                             109 = Claim not covered by this payer/contractor.  You must
                                   send the claim to the correct payer/contractor.
                             110 = Billing date predates service date.
                             111 = Not covered unless the provider accepts assignment.
                             112 = Claim/service adjusted as not furnished directly
                                   to the patient and/or not documented.
                             113 = Claim denied because service/procedure was provided
                                   outside the United States or as a result of war.
                             114 = Procedure/product not approved by the Food and Drug
                                   Administration.
                             115 = Claim/service adjusted as procedure postponed or
                                   canceled.
```

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116 = Claim/service denied.  The advance indemnification
      notice signed by the patient did not comply with
      requirements.
117 = Claim/service adjusted because transportation is only
      covered to the closest facility that can provide
      the necessary care.
118 = Charges reduced for ESRD network support.
119 = Benefit maximum for this time period has been reached.
120 = Patient is covered by a managed care plan. INACTIVE
121 = Indemnification adjustment.
122 = Psychiatric reduction.
123 = Payer refund due to overpayment.  INACTIVE
124 = Payer refund amount - not our patient. INACTIVE
125 = Claim/service adjusted due to a submission/billing
      error(s).
126 = Deductible - Major Medical.
127 = Coinsurance - Major Medical.
128 = Newborn's services are covered in the mother's
      allowance.
129 = Claim denied - prior processing information appears
      incorrect.
130 = Paper claim submission fee.
```

```
1      REV_CNTR_ANSI_TB                        Revenue Center ANSI Code Table
       ----------------                        -----------------------------
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131 = Claim specific negotiated discount.
132 = Prearranged demonstration project adjustment.
133 = The disposition of this claim/service is pending
      further review.
134 = Technical fees removed from charges.
135 = Claim denied.  Interim bills cannot be processed.
136 = Claim adjusted.  Plan procedures of a prior payer
      were not followed.
137 = Payment/Reduction for Regulatory Surcharges, Assess-
      ments, Allowances or Health Related Taxes.
138 = Claim/service denied.  Appeal procedures not
      followed or time limits not met.
139 = Contracted funding agreement - subscriber is employed
      by the provider of services.
140 = Patient/Insured health identification number and name
      do not match.
141 = Claim adjustment because the claim spans eligible
      and ineligible periods of coverage.
142 = Claim adjusted by the monthly Medicaid patient
```

                              liability amount.
A0 = Patient refund amount
A1 = Claim denied charges.
A2 = Contractual adjustment.
A3 = Medicare Secondary Payer liability met. INACTIVE
A4 = Medicare Claim PPS Capital Day Outlier Amount.
A5 = Medicare Claim PPS Capital Cost Outlier Amount.
A6 = Prior hospitalization or 30 day transfer requirement
     not met.
A7 = Presumptive Payment Adjustment.
A8 = Claim denied; ungroupable DRG.
B1 = Non-covered visits.
B2 = Covered visits. INACTIVE
B3 = Covered charges. INACTIVE
B4 = Late filing penalty.
B5 = Claim/service adjusted because coverage/program
     guidelines were not met or were exceeded.
B6 = This service/procedure is adjusted when performed/
     billed by this type of provider, by this type of
     facility, or by a provider of this specialty.
B7 = This provider was not certified/eligible to be
     paid for this procedure/service on this date of
     service.
B8 = Claim/service not covered/reduced because alter-
     native services were available, and should have
     been utilized.
B9 = Services not covered because the patient is en-
     rolled in a Hospice.
B10 = Allowed amount has been reduced because a com-
      ponent of the basic procedure/test was paid. The
      beneficiary is not liable for more than the charge
      limit for the basic procedure/test.
B11 = The claim/service has been transferred to the
      proper payer/processor for processing. Claim/
      service not covered by this payer/processor.
B12 = Services not documented in patients' medical re-
      cords.
B13 = Previously paid. Payment for this claim/service
      may have been provided in a previous payment.
1   REV_CNTR_ANSI_TB   Revenue Center ANSI Code Table
       ----------------   -----------------------------

B14 = Claim/service denied because only one visit or
      consultation per physician per day is covered.

```
           B15 = Claim/service adjusted because this procedure/
                   service is not paid separately.
           B16 = Claim/service adjusted because 'New Patient'
                   qualifications were not met.
           B17 = Claim/service adjusted because this service was
                   not prescribed by a physician, not prescribed
                   prior to delivery, the prescription is incomplete,
                   or the prescription is not current.
           B18 = Claim/service denied because this procedure code/
                   modifier was invalid on the date of service or
                   claim submission.
           B19 = Claim/service adjusted because of the finding of a
                   Review Organization.   INACTIVE
           B20 = Charges adjusted because procedure/service was
                   partially or fully furnished by another provider.
           B21 = The charges were reduced because the service/care
                   was partially furnished by another physician.
                   INACTIVE
           B22 = This claim/service is adjusted based on the
                   diagnosis.
           B23 = Claim/service denied because this provider has
                   failed an aspect of a proficiency testing program.
           W1 = Workers Compensation State Fee Schedule Adjustment.
```

```
1        REV_CNTR_APC_TB                 Revenue Center Ambulatory Payment Classification (APC)
         ---------------                 -------------------------------------------------------


                                         0001 = Photochemotherapy
                                         0002 = Fine needle Biopsy/Aspiration
                                         0003 = Bone Marrow Biopsy/Aspiration
                                         0004 = Level I Needle Biopsy/ Aspiration Except
                                                 Bone Marrow
                                         0005 = Level II Needle Biopsy /Aspiration Except
                                                 Bone Marrow
                                         0006 = Level I Incision & Drainage
                                         0007 = Level II Incision & Drainage
                                         0008 = Level III Incision & Drainage
                                         0009 = Nail Procedures
                                         0010 = Level I Destruction of Lesion
                                         0011 = Level II Destruction of Lesion
                                         0012 = Level I Debridement & Destruction
                                         0013 = Level II Debridement & Destruction
                                         0014 = Level III Debridement & Destruction
```

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0015 = Level IV Debridement & Destruction
0016 = Level V Debridement & Destruction
0017 = Level VI Debridement & Destruction
0018 = Biopsy Skin, Subcutaneous Tissue or Mucous Membrane
0019 = Level I Excision/ Biopsy
0020 = Level II Excision/ Biopsy
0021 = Level III Excision/ Biopsy
0022 = Level IV Excision/ Biopsy
0023 = Exploration Penetrating Wound
0024 = Level I Skin Repair
0025 = Level II Skin Repair
0026 = Level III Skin Repair
0027 = Level IV Skin Repair
0029 = Incision/Excision Breast
0030 = Breast Reconstruction/Mastectomy
0031 = Hyperbaric Oxygen
0032 = Placement Transvenous Catheters/Arterial Cutdown
0033 = Partial Hospitalization
0040 = Arthrocentesis & Ligament/Tendon Injection
0041 = Arthroscopy
0042 = Arthroscopically-Aided Procedures
0043 = Closed Treatment Fracture Finger/Toe/Trunk
0044 = Closed Treatment Fracture/Dislocation Except
       Finger/Toe/Trunk
0045 = Bone/Joint Manipulation Under Anesthesia
0046 = Open/Percutaneous Treatment Fracture or Dislocation
0047 = Arthroplasty without Prosthesis
0048 = Arthroplasty with Prosthesis
0049 = Level I Musculoskeletal Procedures Except Hand
       and Foot
0050 = Level II Musculoskeletal Procedures Except Hand
       and Foot
0051 = Level III Musculoskeletal Procedures Except Hand
       and Foot
0052 = Level IV Musculoskeletal Procedures Except Hand
       and Foot
0053 = Level I Hand Musculoskeletal Procedures
0054 = Level II Hand Musculoskeletal Procedures
0055 = Level I Foot Musculoskeletal Procedures
0056 = Level II Foot Musculoskeletal Procedures
0057 = Bunion Procedures
```

1	REV_CNTR_APC_TB	Revenue Center Ambulatory Payment Classification (APC)
	---------------	--

```
0058 = Level I Strapping and Cast Application
0059 = Level II Strapping and Cast Application
0060 = Manipulation Therapy
0070 = Thoracentesis/Lavage Procedures
0071 = Level I Endoscopy Upper Airway
0072 = Level II Endoscopy Upper Airway
0073 = Level III Endoscopy Upper Airway
0074 = Level IV Endoscopy Upper Airway
0075 = Level V Endoscopy Upper Airway
0076 = Endoscopy Lower Airway
0077 = Level I Pulmonary Treatment
0078 = Level II Pulmonary Treatment
0079 = Ventilation Initiation and Management
0080 = Diagnostic Cardiac Catheterization
0081 = Non-Coronary Angioplasty or Atherectomy
0082 = Coronary Atherectomy
0083 = Coronary Angiosplasty
0084 = Level I Electrophysiologic Evaluation
0085 = Level II Electrophysiologic Evaluation
0086 = Ablate Heart Dysrhythm Focus
0087 = Cardiac Electrophysiologic Recording/Mapping
0088 = Thrombectomy
0089 = Level I Implantation/Removal/Revision of Pacemaker,
       AICD Vascular Device
0090 = Level II Implantation/Removal/Revision of Pacemaker,
       AICD Vascular Device
0091 = Level I Vascular Ligation
0092 = Level II Vascular Ligation
0093 = Vascular Repair/Fistula Construction
0094 = Resuscitation and Cardioversion
0095 = Cardiac Rehabilitation
0096 = Non-Invasive Vascular Studies
0097 = Cardiovascular Stress Test
0098 = Injection of Sclerosing Solution
0099 = Continuous Cardiac Monitoring
0100 = Continuous ECG
0101 = Tilt Table Evaluation
0102 = Electronic Analysis of Pacemakers/other Devices
0109 = Bone Marrow Harvesting and Bone Marrow/Stem Cell
       Transplant
0110 = Transfusion
0111 = Blood Product Exchange
0112 = Extracorporeal Photopheresis
0113 = Excision Lymphatic System
```

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                    0114 = Thyroid/Lymphadenectomy Procedures
                    0116 = Chemotherapy Administration by Other Technique
                           Except Infusion
                    0117 = Chemotherapy Administration by Infusion Only
                    0118 = Chemotherapy Administration by Both Infusion and
                           Other Technique
                    0120 = Infusion Therapy Except Chemotherapy
                    0121 = Level I Tube changes and Repositioning
                    0122 = Level II Tube changes and Repositioning
                    0123 = Level III Tube changes and Repositioning
                    0130 = Level I Laparoscopy
                    0131 = Level II Laparoscopy
                    0132 = Level III Laparoscopy
                    0140 = Esophageal Dilation without Endoscopy
1      REV_CNTR_APC_TB          Revenue Center Ambulatory Payment Classification (APC)
       ---------------          -----------------------------------------------------

                    0141 = Upper GI Procedures
                    0142 = Small Intestine Endoscopy
                    0143 = Lower GI Endoscopy
                    0144 = Diagnostic Anoscopy
                    0145 = Therapeutic Anoscopy
                    0146 = Level I Sigmoidoscopy
                    0147 = Level II Sigmoidoscopy
                    0148 = Level I Anal/Rectal Procedure
                    0149 = Level II Anal/Rectal Procedure
                    0150 = Level III Anal/Rectal Procedure
                    0151 = Endoscopic Retrograde Cholangio-Pancreatography (ERCP)
                    0152 = Percutaneous Biliary Endoscopic Procedures
                    0153 = Peritoneal and Abdominal Procedures
                    0154 = Hernia/Hydrocele Procedures
                    0157 = Colorectal Cancer Screening: Barium Enema
                           (Not subject to National coinsurance)
                    0158 = Colorectal Cancer Screening: Colonoscopy
                           Not subject to National coinsurance.  Minimum
                           unadjusted coinsurance is 25% of the payment rate.
                           Payment rate is lower of the HOPD payment rate or
                           the Ambulatory Surgical Center payment.
                    0159 = Colorectal Cancer Screening: Flexible Sigmoidoscopy
                           Not subject to National coinsurance.  Minimum
                           unadjusted coinsurance is 25% of the payment rate.
                           Payment rate is lower of the HOPD payment rate or
                           the Ambulatory Surgical Center payment.
                    0160 = Level I Cystourethroscopy and other Genitourinary
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            Procedures
0161 = Level II Cystourethroscopy and other Genitourinary
       Procedures
0162 = Level III Cystourethroscopy and other Genitourinary
       Procedures
0163 = Level IV Cystourethroscopy and other Genitourinary
       Procedures
0164 = Level I  Urinary and Anal Procedures
0165 = Level II  Urinary and Anal Procedures
0166 = Level I Urethral Procedures
0167 = Level II Urethral Procedures
0168 = Level III Urethral Procedures
0169 = Lithotripsy
0170 = Dialysis for Other Than ESRD Patients
0180 = Circumcision
0181 = Penile Procedures
0182 = Insertion of Penile Prosthesis
0183 = Testes/Epididymis Procedures
0184 = Prostate Biopsy
0190 = Surgical Hysteroscopy
0191 = Level I Female Reproductive Procedures
0192 = Level II Female Reproductive Procedures
0193 = Level III Female Reproductive Procedures
0194 = Level IV Female Reproductive Procedures
0195 = Level V Female Reproductive Procedures
0196 = Dilatation & Curettage
0197 = Infertility Procedures
0198 = Pregnancy and Neonatal Care Procedures
0199 = Vaginal Delivery
0200 = Therapeutic Abortion
0201 = Spontaneous Abortion
```

1	REV_CNTR_APC_TB	Revenue Center Ambulatory Payment Classification (APC)
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0210 = Spinal Tap
0211 = Level I Nervous System Injections
0212 = Level II Nervous System Injections
0213 = Extended EEG Studies and Sleep Studies
0214 = Electroencephalogram
0215 = Level I Nerve and Muscle Tests
0216 = Level II Nerve and Muscle Tests
0217 = Level III Nerve and Muscle Tests
0220 = Level I Nerve Procedures
0221 = Level II Nerve Procedures
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0222 = Implantation of Neurological Device
0223 = Level I Revision/Removal Neurological Device
0224 = Level II Revision/Removal Neurological Device
0225 = Implantation of Neurostimulator Electrodes
0230 = Level I Eye Tests
0231 = Level II Eye Tests
0232 = Level I Anterior Segment Eye
0233 = Level II Anterior Segment Eye
0234 = Level III Anterior Segment Eye Procedures
0235 = Level I Posterior Segment Eye Procedures
0236 = Level II Posterior Segment Eye Procedures
0237 = Level III Posterior Segment Eye Procedures
0238 = Level I Repair and Plastic Eye Procedures
0239 = Level II Repair and Plastic Eye Procedures
0240 = Level III Repair and Plastic Eye Procedures
0241 = Level IV Repair and Plastic Eye Procedures
0242 = Level V Repair and Plastic Eye Procedures
0243 = Strabismus/Muscle Procedures
0244 = Corneal Transplant
0245 = Cataract Procedures without IOL Insert
0246 = Cataract Procedures with IOL Insert
0247 = Laser Eye Procedures Except Retinal
0248 = Laser Retinal Procedures
0250 = Nasal Cauterization/Packing
0251 = Level I ENT Procedures
0252 = Level II ENT Procedures
0253 = Level III ENT Procedures
0254 = Level IV ENT Procedures
0256 = Level V ENT Procedures
0257 = Implantation of Cochlear Device
0258 = Tonsil and Adenoid Procedures
0260 = Level I Plain Film Except Teeth
0261 = Level II Plain Film Except Teeth Including Bone
       Density Measurement
0262 = Plain Film of Teeth
0263 = Level I Miscellaneous Radiology Procedures
0264 = Level II Miscellaneous Radiology Procedures
0265 = Level I Diagnostic Ultrasound Except Vascular
0266 = Level II Diagnostic Ultrasound Except Vascular
0267 = Vascular Ultrasound
0268 = Guidance Under Ultrasound
0269 = Echocardiogram Except Transesophageal
0270 = Transesophageal Echocardiogram
0271 = Mammography
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                               0272 = Level I Fluoroscopy
                               0273 = Level II Fluoroscopy
                               0274 = Myelography
                               0275 = Arthrography
1        REV_CNTR_APC_TB            Revenue Center Ambulatory Payment Classification (APC)
         ---------------           ------------------------------------------------------

                               0276 = Level I Digestive Radiology
                               0277 = Level II Digestive Radiology
                               0278 = Diagnostic Urography
                               0279 = Level I Diagnostic Angiography and Venography
                                      Except Extremity
                               0280 = Level II Diagnostic Angiography and Venography
                                      Except Extremity
                               0281 = Venography of Extremity
                               0282 = Level I Computerized Axial Tomography
                               0283 = Level II Computerized Axial Tomography
                               0284 = Magnetic Resonance Imaging
                               0285 = Positron Emission Tomography (PET)
                               0286 = Myocardial Scans
                               0290 = Standard Non-Imaging Nuclear Medicine
                               0291 = Level I Diagnostic Nuclear Medicine Excluding
                                      Myocardial Scans
                               0292 = Level II Diagnostic Nuclear Medicine Excluding
                                      Myocardial Scans
                               0294 = Level I Therapeutic Nuclear Medicine
                               0295 = Level II Therapeutic Nuclear Medicine
                               0296 = Level I Therapeutic Radiologic Procedures
                               0297 = Level II Therapeutic Radiologic Procedures
                               0300 = Level I Radiation Therapy
                               0301 = Level II Radiation Therapy
                               0302 = Level III Radiation Therapy
                               0303 = Treatment Device Construction
                               0304 = Level  I Therapeutic Radiation Treatment
                                      Preparation
                               0305 = Level II Therapeutic Radiation Treatment
                                      Preparation
                               0310 = Level III Therapeutic Radiation Treatment
                                      Preparation
                               0311 = Radiation Physics Services
                               0312 = Radioelement Applications
                               0313 = Brachytherapy
                               0314 = Hyperthermic Therapies
                               0320 = Electroconvulsive Therapy
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                              0321 = Biofeedback and Other Training
                              0322 = Brief Individual Psychotherapy
                              0323 = Extended Individual Psychotherapy
                              0324 = Family Psychotherapy
                              0325 = Group Psychotherapy
                              0330 = Dental Procedures
                              0340 = Minor Ancillary Procedures
                              0341 = Immunology Tests
                              0342 = Level I Pathology
                              0343 = Level II Pathology
                              0344 = Level III Pathology
                              0354 = Administration of Influenza Vaccine (Not
                                     subject to national coinsurance)
                              0355 = Level I Immunizations
                              0356 = Level II Immunizations
                              0357 = Level III Immunizations
                              0358 = Level IV Immunizations
                              0359 = Injections
                              0360 = Level I Alimentary Tests
                              0361 = Level II Alimentary Tests
                              0362 = Fitting of Vision Aids
1        REV_CNTR_APC_TB          Revenue Center Ambulatory Payment Classification (APC)
         ---------------          ------------------------------------------------------

                              0363 = Otorhinolaryngologic Function Tests
                              0364 = Level I Audiometry
                              0365 = Level II Audiometry
                              0366 = Electrocardiogram (ECG)
                              0367 = Level I Pulmonary Test
                              0368 = Level II Pulmonary Test
                              0369 = Level III Pulmonary Test
                              0370 = Allergy Tests
                              0371 = Allergy Injections
                              0372 = Therapeutic Phlebotomy
                              0373 = Neuropsychological Testing
                              0374 = Monitoring Psychiatric Drugs
                              0600 = Low Level Clinic Visits
                              0601 = Mid Level Clinic Visits
                              0602 = High Level Clinic Visits
                              0603 = Interdisciplinary Team Conference
                              0610 = Low Level Emergency Visits
                              0611 = Mid Level Emergency Visits
                              0612 = High Level Emergency Visits
                              0620 = Critical Care
```

```
0701 = Strontium (eligible for pass-through payments)
0702 = Samariam (eligible for pass-through payments)
0704 = Satumomab Pendetide (eligible for pass-through
       payments)
0705 = Tc99 Tetrofosmin (eligible for pass-through
       payments)
0725 = Leucovorin Calcium (eligible for pass-through
       payments)
0726 = Dexrazoxane Hydrochloride (eligible for pass-)
       through payments)
0727 = Injection, Etidronate Disodium (eligible for
       pass-through payments)
0728 = Filgrastim (G-CSF) (eligible for pass-through
       payments)
0730 = Pamidronate Disodium (eligible for pass-through
       payments)
0731 = Sargramostim (GM-CSF) (eligible for pass-through
       payments)
0732 = Mesna (eligible for pass-through payments)
0733 = Epoetin Alpha (eligible for pass-through)
       payments)
0750 = Dolasetron Mesylate 10 mg (eligible for pass-
       through payments)
0754 = Metoclopramide HCL (eligible for pass-through
       payments)
0755 = Thiethylperazine Maleate (eligible for pass-through
       payments)
0761 = Oral Substitute for IV Antiemtic (eligible for pass-
       through payments)
0762 = Dronabinol (elibible for pass-through payments)
0763 = Dolasetron Mesylate 100 mg Oral (eligible for
       pass-through payments)
0764 = Granisetron HCL, 100 mcg (eligible for pass-
       through payments)
0765 = Granisetron HCL, 1mg Oral (eligible for pass-
       through payments)
0768 = Ondansetron Hydrochloride per 1 mg Injection
       (eligible for pass-through payments)
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1    REV_CNTR_APC_TB              Revenue Center Ambulatory Payment Classification (APC)
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```
0769 = Ondansetron Hydrochloride 8 mg oral
       (eligible for pass-through payments)
0800 = Leuprolide Acetate per 3.75 mg (eligible for
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pass-through payments)
0801 = Cyclophosphamide (eligible for pass-through
       payments)
0802 = Etoposide (eligible for pass-through payments)
0803 = Melphalan (eligible for pass-through payments)
0807 = Aldesleukin single use vial (eligible for pass-
       through payments)
0809 = BCG (Intravesical) one vial (eligible for pass-
       through payments)
0810 = Goserelin Acetate Implant, per 3.6 mg (eligible for
       pass-through payments)
0811 = Carboplatin 50 mg (eligible for pass-through
       payments)
0812 = Carmustine 100 mg (eligible for pass-through
       payments)
0813 = Cisplatin 10 mg (eligible for pass-through
       payments)
0814 = Asparaginase, 10,000 units (eligible for pass-
       through payments)
0815 = Cyclophosphamide 100 mg (eligible for pass-
       through payments)
0816 = Cyclophosphamide, Lyophilized 100 mg (eligible
       for pass-through payments)
0817 = Cytrabine 100 mg (eligible for pass-through
       payments)
0818 = Dactinomycin 0.5 mg (eligible for pass-through
       payments)
0819 = Dacarbazine 100 mg (eligible for pass-through
       payments)
0820 = Daunorubicin HCI 10 mg (eligible for pass-through
       payments)
0821 = Daunorubicin Citrate, Liposomal Formulation, 10 mg
       (eligible for pass-through payments)
0822 = Diethylstibestrol Diphosphate 250 mg
       (eligible for pass-through payments)
0823 = Docetaxel 20 mg (eligible for pass-through
       payments)
0824 = Etoposide 10 mg (eligible for pass-through
       payments)
0826 = Methotrexate Oral 2.5 mg (eligible for pass-through
       payments)
0827 = Floxuridine 500 mg (eligible for pass-through
       payments)
0828 = Gemcitabine HCL 200 mg (eligibile for pass-

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                          through payments)
            0830 = Irinotecan 20 mg (eligible for pass-through
                   payments)
            0831 = Ifosfamide per 1 gram (eligible for pass-through
                   payments)
            0832 = Idarubicin Hydrochloride 5 mg (eligible for pass-
                   through payments)
            0833 = Interferon Alfacon-1, Recombinant, 1 mcg
                   (eligible for pass-through payments)
            0834 = Interferon,  Alfa-2A, Recombinant 3 million units
                   (eligible for pass-through payments)
1      REV_CNTR_APC_TB          Revenue Center Ambulatory Payment Classification (APC)
       ---------------          ------------------------------------------------------

            0836 = Interferon,  Alfa-2B, Recombinant, 1 million units
                   (eligible for pass-through payments)
            0838 = Interferon, Gamma 1-B, 3 million units
                   (eligible for pass-through payments)
            0839 = Mechlorethamine HCI 10 mg
                   (eligible for pass-through payments)
            0840 = Melphalan HCI 50 mg (eligible for pass-
                   through payments)
            0841 = Methotrexate Sodium 5 mg (eligible for pass-
                   through payments)
            0842 = Fludarabine Phosphate 50 mg (eligible for pass-
                   through payments)
            0843 = Pegaspargase per single dose vial (eligible for
                   pass-through payments)
            0844 = Pentostatin 10 mg (eligible for pass-through
                   payments)
            0847 = Doxorubicin HCL 10 mg (eligible for pass-through
                   payments)
            0849 = Rituximab, 100 mg (eligible for pass-through
                   payments)
            0850 = Streptozocin 1 gm (eligible for pass-through
                   payments)
            0851 = Thiotepa 15 mg (eligible for pass-through pay-
                   ments)
            0852 = Topotecan 4 mg (eligible for pass-through payments)
            0853 = Vinblastine Sulfate 1 mg (eligible for pass-through
                   payments)
            0854 = Vincristine Sulfate 1 mg (eligible for pass-through
                   payments)
            0855 = Vinorelbine Tartrate per 10 mg (eligible for pass-
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                         through payments)
              0856 = Porfimer Sodium 75 mg (eligible for pass-through
                     payments)
              0857 = Bleomycin Sulfate 15 units (eligible for pass-through
                     payments)
              0858 = Cladribine, 1mg (eligible for pass-through payments)
              0859 = Fluorouracil (eligible for pass-through payments)
              0860 = Plicamycin 2.5 mg (eligible for pass-through payments)
              0861 = Leuprolide Acetate 1 mg (eligible for pass-through
                     payments)
              0862 = Mitomycin, 5mg (eligible for pass-through payments)
              0863 = Paclitaxel, 30mg (eligible for pass-through payments)
              0864 = Mitoxantrone HCl,  per 5mg (eligible for pass-through
                     payments)
              0865 = Interferon alfa-N3, 250,000 IU (eligible for pass-
                     through payments)
              0884 = Rho (D) Immune Globulin, Human one dose pack
                     (eligible for pass-through payments)
              0886 = Azathioprine,  50 mg oral
                     (Not subject to national coinsurance)
              0887 = Azathioprine, Parenteral 100 mg, 20 ml each injection
                     (Not subject to national coinsurance)
              0888 = Cyclosporine, Oral 100 mg
                     (Not subject to national coinsurance)
              0889 = Cyclosporine, Parenteral
                     (Not subject to national coinsurance)
              0890 = Lymphocyte Immune Globulin 50 mg/ ml, 5 ml each
                     (Not subject to national coinsurance)
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1      REV_CNTR_APC_TB            Revenue Center Ambulatory Payment Classification (APC)
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              0891 = Tacrolimus per 1 mg oral
                     (Not subject to national coinsurance)
              0892 = Daclizumab, Parenteral, 25 mg
                     (eligible for pass-through payments)
              0900 = Injection, Alglucerase per 10 units
                     (eligible for pass-through payments)
              0901 = Alpha I, Proteinase Inhibitor, Human per 10mg
                     (eligible for pass-through payments)
              0902 = Botulinum Toxin, Type A per unit
                     (eligible for pass-through payments)
              0903 = CMV Immune Globulin
                     (eligible for pass-through payments)
              0905 = Immune Globulin per 500 mg
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        (eligible for pass-through payments)
0906 = RSV Immune Globulin
        (eligible for pass-through payments)
0907 = Ganciclovir Sodium 500 mg injection
        (Not subject to national coinsurance)
0908 = Tetanus Immune Globulin, Human, up to 250 units
        (Not subject to national coinsurance)
0909 = Interferon Beta - 1a   33 mcg (eligible for pass-
        through payments)
0910 = Interferon Beta - 1b   0.25 mg (eligible for pass-
        through payments)
0911 = Streptokinase per 250,000 iu
        (Not subject to national coinsurance)
0913 = Ganciclovir 4.5  mg, Implant (eligible for pass-
        through payments)
0914 = Reteplase, 37.6 mg (Two Single Use Vials)
        (Not subject to national coinsurance)
0915 = Alteplase recombinant, 10mg
        (Not subject to national coinsurance)
0916 = Imiglucerase per unit (eligible for pass-through
        payments)
0917 = Dipyridamole, 10mg / Adenosine 6MG
        (Not subject to national coinsurance)
0918 = Brachytherapy Seeds, Any type, Each (eligible
        for pass-through payments)
0925 = Factor VIII (Antihemophilic Factor, Human) per iu
        (eligible for pass-through payments)
0926 = Factor VIII (Antihemophilic Factor, Porcine) per  iu
        (eligible for pass-through payments)
0927 = Factor VIII (Antihemophilic Factor, Recombinant)
        per iu (eligible for pass-through payments)
0928 = Factor IX,  Complex (eligible for pass-through
        payments)
0929 = Other Hemophilia Clotting Factors per iu (eligible
        for pass-through payments)
0930 = Antithrombin III (Human) per iu (eligible for pass-
        through payments)
0931 = Factor IX (Antihemophilic Factor, Purified, Non-
        Recombinant) (eligible for pass-through payments)
0932 = Factor IX (Antihemophilic Factor, Recombinant)
        (eligible for pass-through payments)
0949 = Plasma, Pooled Multiple Donor, Solvent/Detergent
        Treated, Frozen (not subject to national coinsurance)
0950 = Blood (Whole) For Transfusion (not subject to
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                                    national coinsurance)
1       REV_CNTR_APC_TB                 Revenue Center Ambulatory Payment Classification (APC)
        ---------------                 -------------------------------------------------------

                        0952 = Cryoprecipitate (not subject to national coinsurance)
                        0953 = Fibrinogen Unit (not subject to national coinsurance)
                        0954 = Leukocyte Poor Blood (not subject to national
                               coinsurance)
                        0955 = Plasma, Fresh Frozen (not subject to national
                               coinsurance)
                        0956 = Plasma Protein Fraction (not subject to national
                               coinsurance)
                        0957 = Platelet Concentrate (not subject to national
                               coinsurance)
                        0958 = Platelet Rich Plasma (not subject to national
                               coinsurance)
                        0959 = Red Blood Cells (not subject to national coinsurance)
                        0960 = Washed Red Blood Cells (not subject to national
                               coinsurance)
                        0961 = Infusion, Albumin (Human) 5%, 500 ml
                               (not subject to national coinsurance)
                        0962 = Infusion, Albumin (Human) 25%, 50 ml
                               (not subject to national coinsurance)
                        0970 = New Technology - Level I      ($0 - $50)
                               (not subject to national coinsurance)
                        0971 = New Technology - Level II     ($50 - $100)
                               (not subject to national coinsurance)
                        0972 = New Technology - Level III    ($100 - $200)
                               (not subject to national coinsurance)
                        0973 = New Technology - Level IV    ($200 - $300)
                               (not subject to national coinsurance)
                        0974 = New Technology - Level V     ($300 - $500)
                               (not subject to national coinsurance)
                        0975 = New Technology - Level VI    ($500 - $750)
                               (not subject to national coinsurance)
                        0976 = New Technology - Level VII    ($750 - $1000)
                               (not subject to national coinsurance)
                        0977 = New Technology - Level VIII   ($1000 - $1250)
                               (not subject to national coinsurance)
                        0978 = New Technology - Level IX     ($1250 - $1500)
                               (not subject to national coinsurance)
                        0979 = New Technology - Level X     ($1500 - $1750)
                               (not subject to national coinsurance)
                        0980 = New Technology - Level XI     ($1750 - $2000)
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                        (not subject to national coinsurance)
              0981 = New Technology - Level XII    ($2000 - $2500)
                        (not subject to national coinsurance)
              0982 = New Technology - Level XIII   ($2500 - $3500)
                        (not subject to national coinsurance)
              0983 = New Technology - Level XIV   ($3500 - $5000)
                        (not subject to national coinsurance)
              0984 = New Technology - Level XV    ($5000 - $6000)
                        (not subject to national coinsurance)
              7000 = Amifostine, 500 mg (eligible for pass-through
                        payments)
              7001 = Amphotericin B lipid complex, 50 mg, Inj
                        (eligible for pass-through payments)
              7002 = Clonidine, HCl, 1 MG (eligible for pass-
                        through payments)
              7003 = Epoprostenol, 0.5 MG, inj (eligible for pass-
                        through payments)
              7004 = Immune globulin intravenous human 5g, inj
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1	REV_CNTR_APC_TB	Revenue Center Ambulatory Payment Classification (APC)
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```
                        (eligible for pass-through payments)
              7005 = Gonadorelin hcI, 100 mcg (eligible for pass-
                        through payments)
              7007 = Milrinone lacetate, per 5 ml, inj (not subject
                        to national coinsurance)
              7010 = Morphine sulfate concentrate (preservative free)
                        per 10 mg (eligible for pass-through payments)
              7011 = Oprelevekin, inj, 5 mg (eligible for pass-through
                        payments)
              7012 = Pentamidine isethionate, 300 mg (eligible for
                        pass-through payments)
              7014 = Fentanyl citrate, inj, up to 2 ml (eligible for
                        pass-through payments)
              7015 = Busulfan, oral 2 mg (eligible for pass-through
                        payments)
              7019 = Aprotinin, 10,000 kiu (eligible for pass-through
                        payments)
              7021 = Baclofen, intrathecal, 50 mcg (eligible for pass-
                        through payments)
              7022 = Elliotts B Solution, per ml (eligible for pass-
                        through payments)
              7023 = Treatment for bladder calculi, I.e. Renacidin
                        per 500 ml (eligible for pass-through payments)
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7024 = Corticorelin ovine triflutate, 0.1 mg
       (eligible for pass-through payments)
7025 = Digoxin immune FAB (Ovine), 10 mg
       (eligible for pass-through payments)
7026 = Ethanolamine oleate, 1000 ml
       (eligible for pass-through payments)
7027 = Fomepizole, 1.5 G
       (eligible for pass-through payments)
7028 = Fosphenytoin, 50 mg
       (eligible for pass-through payments)
7029 = Glatiramer acetate, 25 mg
       (eligible for pass-through payments)
7030 = Hemin, 1 mg
       (eligible for pass-through payments)
7031 = Octreotide Acetate, 500 mcg
       (eligible for pass-through payments)
7032 = Sermorelin acetate, 0.5 mg
       (eligible for pass-through payments)
7033 = Somatrem, 5 mg
       (eligible for pass-through payments)
7034 = Somatropin, 1 mg
       (eligible for pass-through payments)
7035 = Teniposide, 50 mg
       (eligible for pass-through payments)
7036 = Urokinase, inj, IV, 250,000 I.U.
       (not subject to national coinsurance)
7037 = Urofollitropin, 75 I.U.
       (eligible for pass-through payments)
7038 = Muromonab-CD3, 5 mg
       (eligible for pass-through payments)
7039 = Pegademase bovine inj 25 I.U.
       (eligible for pass-through payments)
7040 = Pentastarch 10% inj, 100 ml
       (eligible for pass-through payments)
7041 = Tirofiban HCL, 0.5 mg
```

1	REV_CNTR_APC_TB	Revenue Center Ambulatory Payment Classification (APC)
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```
       (not subject to national coinsurance)
7042 = Capecitabine, oral 150 mg
       (eligible for pass-through payments)
7043 = Infliximab, 10 MG (eligible for pass-through
       payments)
7045 = Trimetrexate Glucoronate (eligible for pass-
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                    through payments)
             7046 = Doxorubicin Hcl Liposome (eligible for pass-
                    through payments)

1 REV_CNTR_DDCTBL_COINSRNC_TB   Revenue Center Deductible Coinsurance Code
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             0 = Charges are subject to deductible
                 and coinsurance
             1 = Charges are not subject to deductible
             2 = Charges are not subject to coinsurance
             3 = Charges are not subject to deductible
                 or coinsurance
             4 = No charge or units associated with this
                 revenue center code. (For multiple
                 HCPCS per single revenue center code)

             For revenue center code 0001, the following
             MSP override values may be present:

             M = Override code; EGHP services involved
                 (eff 12/90 for non-institutional claims;
                 10/93 for institutional claims)
             N = Override code; non-EGHP services involved
                 (eff 12/90 for non-institutional claims;
                 10/93 for institutional claims)
             X = Override code: MSP cost avoided
                 (eff 12/90 for non-institutional claims;
                 10/93 for institutional claims)

1   REV_CNTR_PMT_MTHD_IND_TB   Revenue Center Payment Method Indicator Table
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             **********Service Indicator**************
             ********** 1st position ******************
             A = Services not paid under OPPS
             C = Inpatient procedure
             E = Noncovered items or services
             F = Corneal issue acquistion
             G = Current drug or biological pass-through
             H = Device pass-through
             J = New drug or new biological pass-through

N = Packaged incidental service
P = Partial hospitalization services
S = Significant procedure not subject to
    multiple procedure discounting
T = Significant procedure subject to multiple
    procedure discounting
V = Medical visit to clinic or emergency
    department
X = Ancillary service

**********Payment Indicator**************
********** 2nd position *****************
1 = Paid standard hospital OPPS amount
    (service indicators S,T,V,X)
2 = Services not paid under OPPS (service
    indicator A, or no HCPCS code and not
    certain revenue center codes)
3 = Not paid (service indicators C & E)
4 = Acquisition cost paid (service indica-
    tor F)
5 = Additional payment for current drug or
    biological (service indicator G)
6 = Additional payment for device (service
    indicator H)
7 = Additional payment for new drug or new
    biological (service indicator J)
8 = Paid partial hospitalization per diem
    (service indicator P)
9 = No additional payment, payment included
    in line items with APCs (service
    indicator N, or no HCPCS code and certain
    revenue center codes, or HCPCS codes Q0082
    (activity therapy), G0129 (occupational
    therapy) or G0172 (partial hospitalization
    training)

1   REV_CNTR_PRICNG_IND_TB   Revenue Center Pricing Indicator Table
     ----------------------   ---------------------------------------

        A = A valid HCPCS code not subject to a fee schedule payment.
            Reimbursement is calculated on provider submitted

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charges.

B = A valid HCPCS code subject to the fee schedule payment.
Reimbursement is the lesser of provider submitted
charges or the fee schedule amount.

D = a valid radiology HCPCS code subject to the Radiology
Pricer and the rate is reflected as zeroes on the HCPCS
file and cost report. The Radiology Pricer treats this
HCPCS as a non-covered service. Reimbursement is cal-
culated on provider submitted charges.

E = A valid ASC HCPCS code subject to the ASC Pricer. The
rate is reflected as zeroes on the HCPCS file. The
ASC Pricer determines the ASC payment rate and is re-
ported on the cost report.

F = A valid ESRD HCPCS code subject to the parameter rate.
Reimbursement is the lesser of provider submitted
charges or the fee schedule amount for non-dialysis
HCPCS. Reimbursement is calculated on the provider
file rates for dialysis HCPCS.

G = A valid HCPCS, code is subject to a fee schedule, but
the rate is no longer present on the HCPCS file.
Reimbursement is calculated on provider submitted
charges.

H = A valid DME HCPCS, code is subject to a fee schedule.
The rates are reflected under the DME segment. Reim-
bursement is calculated either on a fee schedule, pro-
vider submitted charges or the lesser of provider
submitted, or the fee schedule depending o the cate-
gory.

I = A valid DME category 5 HCPCS, HCPCS is not found on
the DME history record, but a match was found on HIC,
category and generic code. Claim must be reviewed by
Medical Review before payment can be calculated.

J = A valid DME HCPCS, no DME history is present, and a
prescription is required before delivery. Claim must
be reviewed by Medical Review.

K = A valid DME HCPCS, prescribed has been reviewed, and
fee schedule payment is approved as prescription was
present before delivery.

L = A valid TENS HCPCS, rental period is six months or
greater and must be reviewed by Medical Review.

M = A valid TENS HCPCS, Medical Review has approved the
rental charge in excess of five months.

R = A valid radiology HCPCS code and is subject to the
Radiology Pricer. The rate is reported on the cost

                   report. Reimbursement is calculated on provider
                   submitted charges.
           S = Valid influenza/PPV HCPCS. A fee amount is not
                   applicable. The amount payable is present in the
                   covered charge field. This amount is not subject
                   to the coinsurance and deductible. This charge is
                   subject to the provider's reimbursement rate.
           T = Valid HCPCS. A fee amount is present. The amount
                   payable should be the lower of the billed charge or

1   REV_CNTR_PRICNG_IND_TB   Revenue Center Pricing Indicator Table
      ----------------------   --------------------------------------

                   fee amount. The system should compute the fee amount
                   by multiplying the covered units times the rate.
                   The fee amount is not subject to coinsurance and
                   deductible or provider's reimbursement rate.

1   REV_CNTR_TB   Revenue Center Table
          -----------   --------------------

                   0001 = Total charge
                   0022 = SNF claim paid under PPS submitted as TOB 21X,
                           effective for cost reporting periods begin-
                           ning on or after 7/1/98 (dates of service after
                           6/30/98). NOTE: This code may appear multiple
                           times on a claim to identify different HIPPS
                           Rate Code/assessment periods.
                   0023 = Home Health services paid under PPS submitted as
                           TOB 32X and 33X, effective 10/00. This code may
                           appear multiple times on a claim to identify
                           different HIPPS/Home Health Resource Groups (HRG).
                   0100 = All inclusive rate-room and board plus ancillary
                   0101 = All inclusive rate-room and board
                   0110 = Private medical or general-general classification
                   0111 = Private medical or general-medical/surgical/GYN
                   0112 = Private medical or general-OB
                   0113 = Private medical or general-pediatric
                   0114 = Private medical or general-psychiatric
                   0115 = Private medical or general-hospice
                   0116 = Private medical or general-detoxification
                   0117 = Private medical or general-oncology
                   0118 = Private medical or general-rehabilitation
                   0119 = Private medical or general-other

```
                     0120 = Semi-private 2 bed (medical or general)
                            general classification
                     0121 = Semi-private 2 bed (medical or general)
                            medical/surgical/GYN
                     0122 = Semi-private 2 bed (medical or general)-OB
                     0123 = Semi-private 2 bed (medical or general)-pediatric
                     0124 = Semi-private 2 bed (medical or general)-psychiatric
                     0125 = Semi-private 2 bed (medical or general)-hospice
                     0126 = Semi-private 2 bed (medical or general)
                            detoxification
                     0127 = Semi-private 2 bed (medical or general)-oncology
                     0128 = Semi-private 2 bed (medical or general)
                            rehabilitation
                     0129 = Semi-private 2 bed (medical or general)-other
                     0130 = Semi-private 3 and 4 beds-general classification
                     0131 = Semi-private 3 and 4 beds-medical/surgical/GYN
                     0132 = Semi-private 3 and 4 beds-OB
                     0133 = Semi-private 3 and 4 beds-pediatric
                     0134 = Semi-private 3 and 4 beds-psychiatric
                     0135 = Semi-private 3 and 4 beds-hospice
                     0136 = Semi-private 3 and 4 beds-detoxification
                     0137 = Semi-private 3 and 4 beds-oncology
                     0138 = Semi_private 3 and 4 beds-rehabilitation
                     0139 = Semi-private 3 and 4 beds-other
                     0140 = Private (deluxe)-general classification
                     0141 = Private (deluxe)-medical/surgical/GYN
                     0142 = Private (deluxe)-OB
                     0143 = Private (deluxe)-pediatric
                     0144 = Private (deluxe)-psychiatric
                     0145 = Private (deluxe)-hospice
                     0146 = Private (deluxe)-detoxification
                     0147 = Private (deluxe)-oncology
                     0148 = Private (deluxe)-rehabilitation
                     0149 = Private (deluxe)-other
1         REV_CNTR_TB                            Revenue Center Table
          -----------                            --------------------

                     0150 = Room&Board ward (medical or general)
                            general classification
                     0151 = Room&Board ward (medical or general)
                            medical/surgical/GYN
                     0152 = Room&Board ward (medical or general)-OB
                     0153 = Room&Board ward (medical or general)-pediatric
                     0154 = Room&Board ward (medical or general)-psychiatric
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0155 = Room&Board ward (medical or general)-hospice
0156 = Room&Board ward (medical or general)-detoxification
0157 = Room&Board ward (medical or general)-oncology
0158 = Room&Board ward (medical or general)-rehabilitation
0159 = Room&Board ward (medical or general)-other
0160 = Other Room&Board-general classification
0164 = Other Room&Board-sterile environment
0167 = Other Room&Board-self care
0169 = Other Room&Board-other
0170 = Nursery-general classification
0171 = Nursery-newborn
       level I (routine)
0172 = Nursery-premature
       newborn-level II (continuing care)
0173 = Nursery-newborn-level III (intermediate care)
       (eff 10/96)
0174 = Nursery-newborn-level IV (intensive care)
       (eff 10/96)
0175 = Nursery-neonatal ICU (obsolete eff 10/96)
0179 = Nursery-other
0180 = Leave of absence-general classification
0182 = Leave of absence-patient convenience charges
       billable
0183 = Leave of absence-therapeutic leave
0184 = Leave of absence-ICF mentally retarded-any reason
0185 = Leave of absence-nursing home (hospitalization)
0189 = Leave of absence-other leave of absence
0190 = Subacute care - general classification
       (eff. 10/97)
0191 = Subacute care - level I (eff. 10/97)
0192 = Subacute care - level II (eff. 10/97)
0193 = Subacute care - level III (eff. 10/97)
0194 = Subacute care - level IV (eff. 10/97)
0199 = Subacute care - other (eff 10/97)
0200 = Intensive care-general classification
0201 = Intensive care-surgical
0202 = Intensive care-medical
0203 = Intensive care-pediatric
0204 = Intensive care-psychiatric
0206 = Intensive care-post ICU; redefined as
       intermediate ICU (eff 10/96)
0207 = Intensive care-burn care
0208 = Intensive care-trauma
0209 = Intensive care-other intensive care
```

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                              0210 = Coronary care-general classification
                              0211 = Coronary care-myocardial infraction
                              0212 = Coronary care-pulmonary care
                              0213 = Coronary care-heart transplant
                              0214 = Coronary care-post CCU; redefined as
                                     intermediate CCU (eff 10/96)
                              0219 = Coronary care-other coronary care
```

1   REV_CNTR_TB   Revenue Center Table
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                              0220 = Special charges-general classification
                              0221 = Special charges-admission charge
                              0222 = Special charges-technical support charge
                              0223 = Special charges-UR service charge
                              0224 = Special charges-late discharge, medically
                                     necessary
                              0229 = Special charges-other special charges
                              0230 = Incremental nursing charge rate-general
                                     classification
                              0231 = Incremental nursing charge rate-nursery
                              0232 = Incremental nursing charge rate-OB
                              0233 = Incremental nursing charge rate-ICU (include
                                     transitional care)
                              0234 = Incremental nursing charge rate-CCU (include
                                     transitional care)
                              0235 = Incremental nursing charge rate-hospice
                              0239 = Incremental nursing charge rate-other
                              0240 = All inclusive ancillary-general classification
                              0241 = All inclusive ancillary-basic
                              0242 = All inclusive ancillary-comprehensive
                              0243 = All inclusive ancillary-specialty
                              0249 = All inclusive ancillary-other inclusive ancillary
                              0250 = Pharmacy-general classification
                              0251 = Pharmacy-generic drugs
                              0252 = Pharmacy-nongeneric drugs
                              0253 = Pharmacy-take home drugs
                              0254 = Pharmacy-drugs incident to other diagnostic service-
                                     subject to payment limit
                              0255 = Pharmacy-drugs incident to radiology-
                                     subject to payment limit
                              0256 = Pharmacy-experimental drugs
                              0257 = Pharmacy-non-prescription
                              0258 = Pharmacy-IV solutions
                              0259 = Pharmacy-other pharmacy
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0260 = IV therapy-general classification
0261 = IV therapy-infusion pump
0262 = IV therapy-pharmacy services (eff 10/94)
0263 = IV therapy-drug supply/delivery (eff 10/94)
0264 = IV therapy-supplies (eff 10/94)
0269 = IV therapy-other IV therapy
0270 = Medical/surgical supplies-general classification
       (also see 062X)
0271 = Medical/surgical supplies-nonsterile supply
0272 = Medical/surgical supplies-sterile supply
0273 = Medical/surgical supplies-take home supplies
0274 = Medical/surgical supplies-prosthetic/orthotic
       devices
0275 = Medical/surgical supplies-pace maker
0276 = Medical/surgical supplies-intraocular lens
0277 = Medical/surgical supplies-oxygen-take home
0278 = Medical/surgical supplies-other implants
0279 = Medical/surgical supplies-other devices
0280 = Oncology-general classification
0289 = Oncology-other oncology
0290 = DME (other than renal)-general classification
0291 = DME (other than renal)-rental
0292 = DME (other than renal)-purchase of new DME
0293 = DME (other than renal)-purchase of used DME
```

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1        REV_CNTR_TB                              Revenue Center Table
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0294 = DME (other than renal)-related to and listed as DME
0299 = DME (other than renal)-other
0300 = Laboratory-general classification
0301 = Laboratory-chemistry
0302 = Laboratory-immunology
0303 = Laboratory-renal patient (home)
0304 = Laboratory-non-routine dialysis
0305 = Laboratory-hematology
0306 = Laboratory-bacteriology & microbiology
0307 = Laboratory-urology
0309 = Laboratory-other laboratory
0310 = Laboratory pathological-general classification
0311 = Laboratory pathological-cytology
0312 = Laboratory pathological-histology
0314 = Laboratory pathological-biopsy
0319 = Laboratory pathological-other
0320 = Radiology diagnostic-general classification
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0321 = Radiology diagnostic-angiocardiography
0322 = Radiology diagnostic-arthrography
0323 = Radiology diagnostic-arteriography
0324 = Radiology diagnostic-chest X-ray
0329 = Radiology diagnostic-other
0330 = Radiology therapeutic-general classification
0331 = Radiology therapeutic-chemotherapy injected
0332 = Radiology therapeutic-chemotherapy oral
0333 = Radiology therapeutic-radiation therapy
0335 = Radiology therapeutic-chemotherapy IV
0339 = Radiology therapeutic-other
0340 = Nuclear medicine-general classification
0341 = Nuclear medicine-diagnostic
0342 = Nuclear medicine-therapeutic
0349 = Nuclear medicine-other
0350 = Computed tomographic (CT) scan-general
       classification
0351 = CT scan-head scan
0352 = CT scan-body scan
0359 = CT scan-other CT scans
0360 = Operating room services-general classification
0361 = Operating room services-minor surgery
0362 = Operating room services-organ transplant,
       other than kidney
0367 = Operating room services-kidney transplant
0369 = Operating room services-other operating room
       services
0370 = Anesthesia-general classification
0371 = Anesthesia-incident to RAD and
       subject to the payment limit
0372 = Anesthesia-incident to other diagnostic service
       and subject to the payment limit
0374 = Anesthesia-acupuncture
0379 = Anesthesia-other anesthesia
0380 = Blood-general classification
0381 = Blood-packed red cells
0382 = Blood-whole blood
0383 = Blood-plasma
0384 = Blood-platelets
0385 = Blood-leukocytes
0386 = Blood-other components
```

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1      REV_CNTR_TB                                    Revenue Center Table
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0387 = Blood-other derivatives (cryopricipatates)
0389 = Blood-other blood
0390 = Blood storage and processing-general
       classification
0391 = Blood storage and processing-blood
       administration
0399 = Blood storage and processing-other
0400 = Other imaging services-general classification
0401 = Other imaging services-diagnostic mammography
0402 = Other imaging services-ultrasound
0403 = Other imaging services-screening mammography
       (eff 1/1/91)
0404 = Other imaging services-positron emission
       tomography (eff 10/94)
0409 = Other imaging services-other
0410 = Respiratory services-general classification
0412 = Respiratory services-inhalation services
0413 = Respiratory services-hyperbaric oxygen therapy
0419 = Respiratory services-other
0420 = Physical therapy-general classification
0421 = Physical therapy-visit charge
0422 = Physical therapy-hourly charge
0423 = Physical therapy-group rate
0424 = Physical therapy-evaluation or re-evaluation
0429 = Physical therapy-other
0430 = Occupational therapy-general classification
0431 = Occupational therapy-visit charge
0432 = Occupational therapy-hourly charge
0433 = Occupational therapy-group rate
0434 = Occupational therapy-evaluation or re-evaluation
0439 = Occupational therapy-other (may include
       restorative therapy)
0440 = Speech language pathology-general classification
0441 = Speech language pathology-visit charge
0442 = Speech language pathology-hourly charge
0443 = Speech language pathology-group rate
0444 = Speech language pathology-evaluation or
       re-evaluation
0449 = Speech language pathology-other
0450 = Emergency room-general classification
0451 = Emergency room-emtala emergency medical screening
       services (eff 10/96)
0452 = Emergency room-ER beyond emtala screening
       (eff 10/96)
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                        0456 = Emergency room-urgent care (eff 10/96)
                        0459 = Emergency room-other
                        0460 = Pulmonary function-general classification
                        0469 = Pulmonary function-other
                        0470 = Audiology-general classification
                        0471 = Audiology-diagnostic
                        0472 = Audiology-treatment
                        0479 = Audiology-other
                        0480 = Cardiology-general classification
                        0481 = Cardiology-cardiac cath lab
                        0482 = Cardiology-stress test
                        0483 = Cardiology-Echocardiology
                        0489 = Cardiology-other
                        0490 = Ambulatory surgical care-general classification
```

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1          REV_CNTR_TB                            Revenue Center Table
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                        0499 = Ambulatory surgical care-other
                        0500 = Outpatient services-general classification
                               (deleted 9/93)
                        0509 = Outpatient services-other (deleted 9/93)
                        0510 = Clinic-general classification
                        0511 = Clinic-chronic pain center
                        0512 = Clinic-dental center
                        0513 = Clinic-psychiatric
                        0514 = Clinic-OB-GYN
                        0515 = Clinic-pediatric
                        0516 = Clinic-urgent care clinic (eff 10/96)
                        0517 = Clinic-family practice clinic (eff 10/96)
                        0519 = Clinic-other
                        0520 = Free-standing clinic-general classification
                        0521 = Free-standing clinic-rural health clinic
                        0522 = Free-standing clinic-rural health home
                        0523 = Free-standing clinic-family practice
                        0526 = Free-standing clinic-urgent care (eff 10/96)
                        0529 = Free-standing clinic-other
                        0530 = Osteopathic services-general classification
                        0531 = Osteopathic services-osteopathic therapy
                        0539 = Osteopathic services-other
                        0540 = Ambulance-general classification
                        0541 = Ambulance-supplies
                        0542 = Ambulance-medical transport
                        0543 = Ambulance-heart mobile
                        0544 = Ambulance-oxygen
```

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0545 = Ambulance-air ambulance
0546 = Ambulance-neo-natal ambulance
0547 = Ambulance-pharmacy
0548 = Ambulance-telephone transmission EKG
0549 = Ambulance-other
0550 = Skilled nursing-general classification
0551 = Skilled nursing-visit charge
0552 = Skilled nursing-hourly charge
0559 = Skilled nursing-other
0560 = Medical social services-general classification
0561 = Medical social services-visit charge
0562 = Medical social services-hourly charges
0569 = Medical social services-other
0570 = Home health aid (home health)-general
       classification
0571 = Home health aid (home health)-visit charge
0572 = Home health aid (home health)-hourly charge
0579 = Home health aid (home health)-other
0580 = Other visits (home health)-general
       classification (under HHPPS, not allowed
       as covered charges)
0581 = Other visits (home health)-visit charge
       (under HHPPS, not allowed as covered charges)
0582 = Other visits (home health)-hourly charge
       (under HHPPS, not allowed as covered charges)
0589 = Other visits (home health)-other
       (under HHPPS, not allowed as covered charges)
0590 = Units of service (home health)-general
       classification (under HHPPS, not allowed
       as covered charges)
0599 = Units of service (home health)-other
```

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1        REV_CNTR_TB                            Revenue Center Table
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                       (under HHPPS, not allowed as covered charges)
0600 = Oxygen-general classification
0601 = Oxygen-stat or port equip/supply or count
0602 = Oxygen-stat/equip/under 1 LPM
0603 = Oxygen-stat/equip/over 4 LPM
0604 = Oxygen-stat/equip/portable add-on
0610 = Magnetic resonance technology (MRT)-general
       classification
0611 = MRT/MRI-brain (including brainstem)
0612 = MRT/MRI-spinal cord (including spine)
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0614 = MRT/MRI-other
0615 = MRT/MRA-Head and Neck
0616 = MRT/MRA-Lower Extremities
0618 = MRT/MRA-other
0619 = MRT/Other MRI
0621 = Medical/surgical supplies-incident to radiology-
       subject to the payment limit - extension of 027X
0622 = Medical/surgical supplies-incident to other
       diagnostic service-subject to the payment limit -
       extension of 027X
0623 = Medical/surgical supplies-surgical dressings
       (eff 1/95) - extension of 027X
0624 = Medical/surgical supplies-medical investigational
       devices and procedures with FDA approved IDE's
       (eff 10/96) - extension of 027X
0630 = Drugs requiring specific identification-general
       classification
0631 = Drugs requiring specific identification-single drug
       source (eff 9/93)
0632 = Drugs requiring specific identification-multiple drug
       source (eff 9/93)
0633 = Drugs requiring specific identification-restrictive
       prescription (eff 9/93)
0634 = Drugs requiring specific identification-EPO under
       10,000 units
0635 = Drugs requiring specific identification-EPO 10,000
       units or more
0636 = Drugs requiring specific identification-detailed
       coding (eff 3/92)
0637 = Self-administered drugs administered in an
       emergency situation - not requiring detailed
       coding
0640 = Home IV therapy-general classification
       (eff 10/94)
0641 = Home IV therapy-nonroutine nursing
       (eff 10/94)
0642 = Home IV therapy-IV site care, central line
       (eff 10/94)
0643 = Home IV therapy-IV start/change peripheral line
       (eff 10/94)
0644 = Home IV therapy-nonroutine nursing, peripheral line
       (eff 10/94)
0645 = Home IV therapy-train patient/caregiver, central
       line (eff 10/94)
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                                  0646 = Home IV therapy-train disabled patient, central
                                         line (eff 10/94)
                                  0647 = Home IV therapy-train patient/caregiver, peripheral
                                         line (eff 10/94)
1          REV_CNTR_TB                              Revenue Center Table
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                                  0648 = Home IV therapy-train disabled patient, peripheral
                                         line (eff 10/94)
                                  0649 = Home IV therapy-other IV therapy services
                                         (eff 10/94)
                                  0650 = Hospice services-general classification
                                  0651 = Hospice services-routine home care
                                  0652 = Hospice services-continuous home care-1/2
                                  0655 = Hospice services-inpatient care
                                  0656 = Hospice services-general inpatient care
                                         (non-respite)
                                  0657 = Hospice services-physician services
                                  0659 = Hospice services-other
                                  0660 = Respite care (HHA)-general classification
                                         (eff 9/93)
                                  0661 = Respite care (HHA)-hourly charge/skilled nursing
                                         (eff 9/93)
                                  0662 = Respite care (HHA)-hourly charge/home health aide/
                                         homemaker (eff 9/93)
                                  0670 = OP special residence charges - general
                                         classification
                                  0671 = OP special residence charges - hospital based
                                  0672 = OP special residence charges - contracted
                                  0679 = OP special residence charges - other special
                                         residence charges
                                  0700 = Cast room-general classification
                                  0709 = Cast room-other
                                  0710 = Recovery room-general classification
                                  0719 = Recovery room-other
                                  0720 = Labor room/delivery-general classification
                                  0721 = Labor room/delivery-labor
                                  0722 = Labor room/delivery-delivery
                                  0723 = Labor room/delivery-circumcision
                                  0724 = Labor room/delivery-birthing center
                                  0729 = Labor room/delivery-other
                                  0730 = EKG/ECG-general classification
                                  0731 = EKG/ECG-Holter moniter
                                  0732 = EKG/ECG-telemetry (include fetal monitering until
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                9/93)
        0739 = EKG/ECG-other
        0740 = EEG-general classification
        0749 = EEG (electroencephalogram)-other
        0750 = Gastro-intestinal services-general classification
        0759 = Gastro-intestinal services-other
        0760 = Treatment or observation room-general
               classification
        0761 = Treatment or observation room-treatment room
               (eff 9/93)
        0762 = Treatment or observation room-observation room
               (eff 9/93)
        0769 = Treatment or observation room-other
        0770 = Preventative care services-general classification
               (eff 10/94)
        0771 = Preventative care services-vaccine administration
               (eff 10/94)
        0779 = Preventative care services-other (eff 10/94)
        0780 = Telemedicine - general classification
               (eff 10/97)
        0789 = Telemedicine - telemedicine (eff 10/97)

1   REV_CNTR_TB   Revenue Center Table
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        0790 = Lithotripsy-general classification
        0799 = Lithotripsy-other
        0800 = Inpatient renal dialysis-general classification
        0801 = Inpatient renal dialysis-inpatient hemodialysis
        0802 = Inpatient renal dialysis-inpatient peritoneal
               (non-CAPD)
        0803 = Inpatient renal dialysis-inpatient CAPD
        0804 = Inpatient renal dialysis-inpatient CCPD
        0809 = Inpatient renal dialysis-other inpatient dialysis
        0810 = Organ acquisition-general classification
        0811 = Organ acquisition-living donor (eff 10/94);
               prior to 10/94, defined as living donor kidney
        0812 = Organ acquisition-cadaver donor (eff 10/94);
               prior to 10/94, defined as cadaver donor kidney
        0813 = Organ acquisition-unknown donor (eff 10/94)
               prior to 10/94, defined as unknown donor kidney
        0814 = Organ acquisition - unsuccessful organ search-
               donor bank charges (eff 10/94); prior to 10/94,
               defined as other kidney acquisition
        0815 = Organ acquisition-cadaver donor-heart

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```
                          (obsolete, eff 10/94)
         0816 = Organ acquisition-other heart acquisition
                          (obsolete, eff 10/94)
         0817 = Organ acquisition-donor-liver
                          (obsolete, eff 10/94)
         0819 = Organ acquisition-other donor (eff 10/94);
                          prior to 10/94, defined as other
         0820 = Hemodialysis OP or home dialysis-general
                          classification
         0821 = Hemodialysis OP or home dialysis-hemodialysis-
                          composite or other rate
         0822 = Hemodialysis OP or home dialysis-home supplies
         0823 = Hemodialysis OP or home dialysis-home equipment
         0824 = Hemodialysis OP or home dialysis-maintenance/100%
         0825 = Hemodialysis OP or home dialysis-support services
         0829 = Hemodialysis OP or home dialysis-other
         0830 = Peritoneal dialysis OP or home-general
                          classification
         0831 = Peritoneal dialysis OP or home-peritoneal-
                          composite or other rate
         0832 = Peritoneal dialysis OP or home-home supplies
         0833 = Peritoneal dialysis OP or home-home equipment
         0834 = Peritoneal dialysis OP or home-maintenance/100%
         0835 = Peritoneal dialysis OP or home-support services
         0839 = Peritoneal dialysis OP or home-other
         0840 = CAPD outpatient-general classification
         0841 = CAPD outpatient-CAPD/composite or other rate
         0842 = CAPD outpatient-home supplies
         0843 = CAPD outpatient-home equipment
         0844 = CAPD outpatient-maintenance/100%
         0845 = CAPD outpatient-support services
         0849 = CAPD outpatient-other
         0850 = CCPD outpatient-general classification
         0851 = CCPD outpatient-CCPD/composite or other rate
         0852 = CCPD outpatient-home supplies
         0853 = CCPD outpatient-home equipment
         0854 = CCPD outpatient-maintenance/100%
         0855 = CCPD outpatient-support services
```

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1        REV_CNTR_TB                              Revenue Center Table
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```
         0859 = CCPD outpatient-other
         0880 = Miscellaneous dialysis-general classification
         0881 = Miscellaneous dialysis-ultrafiltration
```

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0882 = Miscellaneous dialysis-home dialysis aide visit
       (eff 9/93)
0889 = Miscellaneous dialysis-other
0890 = Other donor bank-general classification; changed to
       reserved for national assignment (eff 4/94)
0891 = Other donor bank-bone; changed to
       reserved for national assignment (eff 4/94)
0892 = Other donor bank-organ (other than kidney); changed
       to reserved for national assignment (eff 4/94)
0893 = Other donor bank-skin; changed to
       reserved for national assignment (eff 4/94)
0899 = Other donor bank-other; changed to
       reserved for national assignment (eff 4/94)
0900 = Psychiatric/psychological treatments-general
       classification
0901 = Psychiatric/psychological treatments-electroshock
       treatment
0902 = Psychiatric/psychological treatments-milieu
       therapy
0903 = Psychiatric/psychological treatments-play
       therapy
0904 = Psychiatric/psychological treatments-activity
       therapy (eff 4/94)
0909 = Psychiatric/psychological treatments-other
0910 = Psychiatric/psychological services-general
       classification
0911 = Psychiatric/psychological services-rehabilitation
0912 = Psychiatric/psychological services-day care-
       redefined 10/97 to less Intensive
0913 = Psychiatric/psychological services-night care
       redefined 10/97 to Intensive
0914 = Psychiatric/psychological services-individual
       therapy
0915 = Psychiatric/psychological services-group therapy
0916 = Psychiatric/psychological services-family therapy
0917 = Psychiatric/psychological services-biofeedback
0918 = Psychiatric/psychological services-testing
0919 = Psychiatric/psychological services-other
0920 = Other diagnostic services-general classification
0921 = Other diagnostic services-peripheral vascular lab
0922 = Other diagnostic services-electromyelogram
0923 = Other diagnostic services-pap smear
0924 = Other diagnostic services-allergy test
0925 = Other diagnostic services-pregnancy test
```

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                            0929 = Other diagnostic services-other
                            0940 = Other therapeutic services-general classification
                            0941 = Other therapeutic services-recreational therapy
                            0942 = Other therapeutic services-education/training
                                   (include diabetes diet training)
                            0943 = Other therapeutic services-cardiac rehabilitation
                            0944 = Other therapeutic services-drug rehabilitation
                            0945 = Other therapeutic services-alcohol
                                   rehabilitation
                            0946 = Other therapeutic services-routine complex
                                   medical equipment
1          REV_CNTR_TB                              Revenue Center Table
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                            0947 = Other therapeutic services-ancillary complex
                                   medical equipment (eff 3/92)
                            0949 = Other therapeutic services-other
                            0951 = Professional Fees-athletic training
                            0952 = Professional Fees-kinesiotherapy
                            0960 = Professional fees-general classification
                            0961 = Professional fees-psychiatric
                            0962 = Professional fees-ophthalmology
                            0963 = Professional fees-anesthesiologist (MD)
                            0964 = Professional fees-anesthetist (CRNA)
                            0969 = Professional fees-other
                            0971 = Professional fees-laboratory
                            0972 = Professional fees-radiology diagnostic
                            0973 = Professional fees-radiology therapeutic
                            0974 = Professional fees-nuclear medicine
                            0975 = Professional fees-operating room
                            0976 = Professional fees-respiratory therapy
                            0977 = Professional fees-physical therapy
                            0978 = Professional fees-occupational therapy
                            0979 = Professional fees-speech pathology
                            0981 = Professional fees-emergency room
                            0982 = Professional fees-outpatient services
                            0983 = Professional fees-clinic
                            0984 = Professional fees-medical social services
                            0985 = Professional fees-EKG
                            0986 = Professional fees-EEG
                            0987 = Professional fees-hospital visit
                            0988 = Professional fees-consultation
                            0989 = Professional fees-private duty nurse
                            0990 = Patient convenience items-general classification
```

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                     0991 = Patient convenience items-cafeteria/guest tray
                     0992 = Patient convenience items-private linen service
                     0993 = Patient convenience items-telephone/telegraph
                     0994 = Patient convenience items-tv/radio
                     0995 = Patient convenience items-nonpatient room rentals
                     0996 = Patient convenience items-late discharge charge
                     0997 = Patient convenience items-admission kits
                     0998 = Patient convenience items-beauty shop/barber
                     0999 = Patient convenience items-other

                     NOTE: Following Revenue Codes reported
                     for NHCMQ (RUGS) demo claims effective
                     2/96.

                     9000 = RUGS-no MDS assessment available
                     9001 = Reduced physical functions-
                          RUGS PA1/ADL index of 4-5
                     9002 = Reduced physical functions-
                          RUGS PA2/ADL index of 4-5
                     9003 = Reduced physical functions-
                          RUGS PB1/ADL index of 6-8
                     9004 = Reduced physical functions-
                          RUGS PB2/ADL index of 6-8
                     9005 = Reduced physical functions-
                          RUGS PC1/ADL index of 9-10
                     9006 = Reduced physical functions-
                          RUGS PC2/ADL index of 9-10
                     9007 = Reduced physical functions-
```
```
1        REV_CNTR_TB                          Revenue Center Table
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```
                          RUGS PD1/ADL index of 11-15
                     9008 = Reduced physical functions-
                          RUGS PD2/ADL index of 11-15
                     9009 = Reduced physical functions-
                          RUGS PE1/ADL index of 16-18
                     9010 = Reduced physical functions-
                          RUGS PE2/ADL index of 16-18
                     9011 = Behavior only problems-
                          RUGS BA1/ADL index of 4-5
                     9012 = Behavior only problems-
                          RUGS BA2/ADL index of 4-5
                     9013 = Behavior only problems-
                          RUGS BB1/ADL index of 6-10
```

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9014 = Behavior only problems-
       RUGS BB2/ADL index of 6-10
9015 = Impaired cognition-
       RUGS IA1/ADL index of 4-5
9016 = Impaired cognition-
       RUGS IA2/ADL index of 4-5
9017 = Impaired cognition-
       RUGS IB1/ADL index of 6-10
9018 = Impaired cognition-
       RUGS IB2/ADL index of 6-10
9019 = Clinically complex-
       RUGS CA1/ADL index of 4-5
9020 = Clinically complex-
       RUGS CA2/ADL index of 4-5d
9021 = Clinically complex-
       RUGS CB1/ADL index of 6-10
9022 = Clinically complex-
       RUGS CB2/ADL index of 6-10d
9023 = Clinically complex-
       RUGS CC1/ADL index of 11-16
9024 = Clinically complex-
       RUGS CC2/ADL index of 11-16d
9025 = Clinically complex-
       RUGS CD1/ADL index of 17-18
9026 = Clinically complex-
       RUGS CD2/ADL index of 17-18d
9027 = Special care-
       RUGS SSA/ADL index of 7-13
9028 = Special care-
       RUGS SSB/ADL index of 14-16
9029 = Special care-
       RUGS SSC/ADL index of 17-18
9030 = Extensive services-
       RUGS SE1/1 procedure
9031 = Extensive services-
       RUGS SE2/2 procedures
9032 = Extensive services-
       RUGS SE3/3 procedures
9033 = Low rehabilitation-
       RUGS RLA/ADL index of 4-11
9034 = Low rehabilitation-
       RUGS RLB/ADL index of 12-18
9035 = Medium rehabilitation-
       RUGS RMA/ADL index of 4-7
```

                                      9036 = Medium rehabilitation-
1   REV_CNTR_TB   Revenue Center Table
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                                             RUGS RMB/ADL index of 8-15
                                      9037 = Medium rehabilitation-
                                             RUGS RMC/ADL index of 16-18
                                      9038 = High rehabilitation-
                                             RUGS RHA/ADL index of 4-7
                                      9039 = High rehabilitation-
                                             RUGS RHB/ADL index of 8-11
                                      9040 = High rehabilitation-
                                             RUGS RHC/ADL index of 12-14
                                      9041 = High rehabilitation-
                                             RUGS RHD/ADL index of 15-18
                                      9042 = Very high rehabilitation-
                                             RUGS RVA/ADL index of 4-7
                                      9043 = Very high rehabilitation-
                                             RUGS RVB/ADL index of 8-13
                                      9044 = Very high rehabilitation-
                                             RUGS RVC/ADL index of 14-18

                                      Changes effective for providers entering
                                      RUGS Demo Phase III as of 1/1/97 or later

                                      9019 = Clinically complex-
                                             RUGS CA1/ADL index of 11
                                      9020 = Clinically complex-
                                             RUGS CA2/ADL index of 11D
                                      9021 = Clinically complex-
                                             RUGS CB1/ADL index of 12-16
                                      9022 = Clinically complex-
                                             RUGS CB2/ADL index of 12-16D
                                      9023 = Clinically complex-
                                             RUGS CC1/ADL index of 17-18
                                      9024 = Clinically complex-
                                             RUGS CC2/ADL index of 17-18D
                                      9025 = Special care-
                                             RUGS SSA/ADL index of 14
                                      9026 = Special care-
                                             RUGS SSB/ADL index of 15-16
                                      9027 = Special care-
                                             RUGS SSC/ADL index of 17-18
                                      9028 = Extensive services-

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                             RUGS SE1/ADL index 7-18/1 procedure
                 9029 = Extensive services-
                             RUGS SE2/ADL index 7-18/2 procedures
                 9030 = Extensive services-
                             RUGS SE3/ADL index 7-18/3 procedures
                 9031 = Low rehabilitation-
                             RUGS RLA/ADL index of 4-13
                 9032 = Low rehabilitation-
                             RUGS RLB/ADL index of 14-18
                 9033 = Medium rehabilitation-
                             RUGS RMA/ADL index of 4-7
                 9034 = Medium rehabilitation-
                             RUGS RMB/ADL index of 8-14
                 9035 = Medium rehabilitation-
                             RUGS RMC/ADL index of 15-18
                 9036 = High rehabilitation-
                             RUGS RHA/ADL index of 4-7
                 9037 = High rehabilitation-
1        REV_CNTR_TB                              Revenue Center Table
         -----------                              --------------------

                             RUGS RHB/ADL index of 8-12
                 9038 = High rehabilitation-
                             RUGS RHC/ADL index of 13-18
                 9039 = Very High rehabilitation-
                             RUGS RVA/ADL index of 4-8
                 9040 = Very high rehabilitation-
                             RUGS RVB/ADL index of 9-15
                 9041 = Very high rehabilitation-
                             RUGS RVC/ADL index of 16
                 9042 = Very high rehabilitation-
                             RUGS RUA/ADL index of 4-8
                 9043 = Very high rehabilitation-
                             RUGS RUB/ADL index of 9-15
                 9044 = Ultra high rehabilitation-
                             RUGS RUC/ADL index of 16-18
```